

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

250

50 1501

BALTIMORE CITY HEALTH DEPARTMENT

50 1501

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNA B. LASSAHN

2. DATE
OF
DEATH

Feb. 19th, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

2332 E. Hoffman Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2332 E. Hoffman Street

c. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Sept. 29th, 1868

9. AGE (In years
last birthday)

81

If Under 1 Year
Months Days
If Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

--

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Hoffman

14. MOTHER'S MAIDEN NAME

Katherine Koffenberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

--

17. INFORMANT

ADDRESS

Miss Irene Lassahn, 2332 E. Hoffman St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Carcinoma of stomach and pancreas.

DUE TO

4 Mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Oct. 10, 1949 to Feb. 19, 1950, that I last saw the deceased alive on Feb. 19, 1950, and that death occurred at 2 P. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

burial

Feb. 22, 1950

Parkwood

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1950

1950

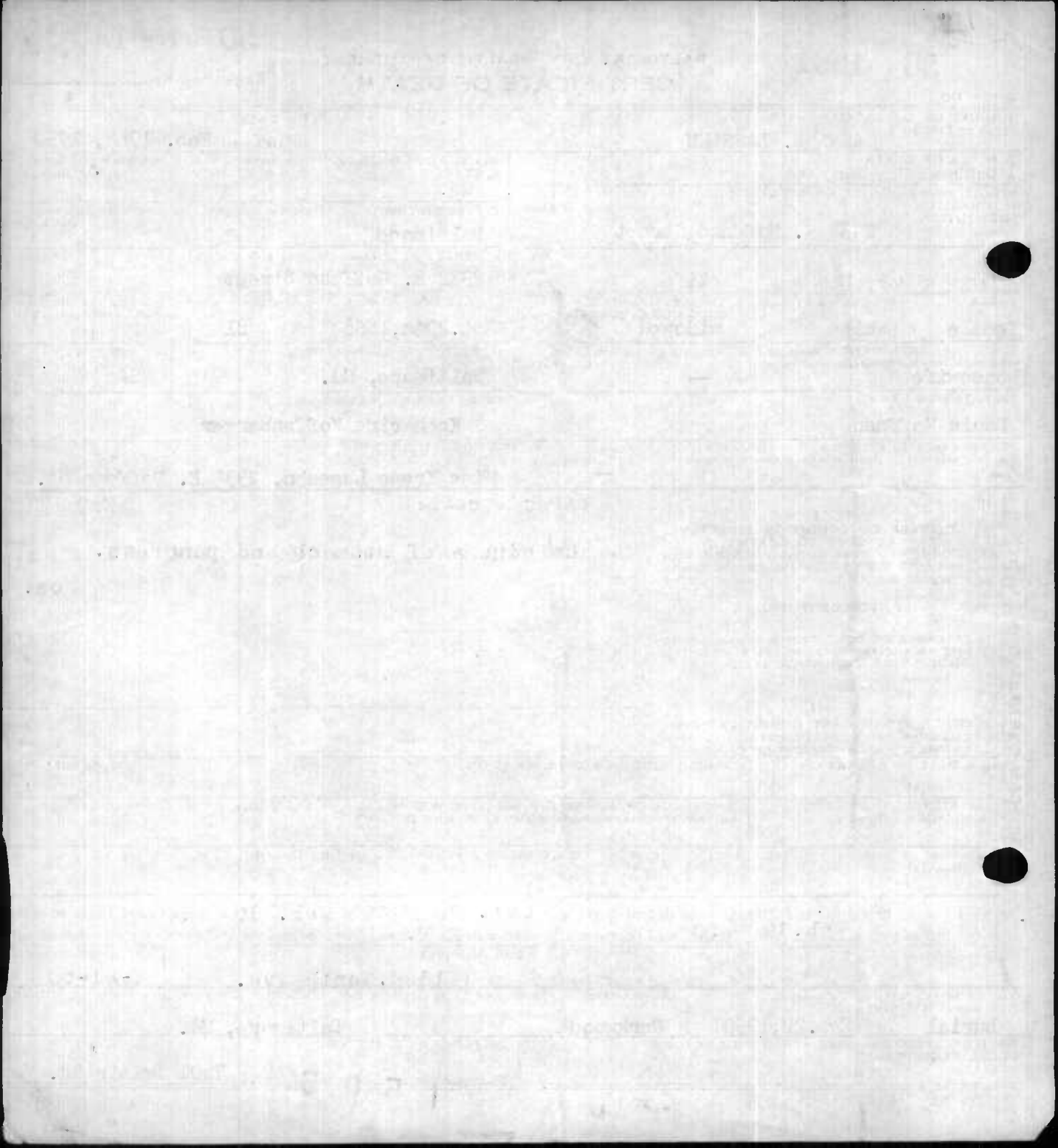
7401 Belair Rd.

FEB 29 1950

1950

1950

46B



1502 1502

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1502

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

GEORGE McCOMBE Sr.

2. DATE

OF

DEATH February 15, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

No home

Length of stay in Baltimore

27 Yrs

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1893 ?

9. AGE (In years last birthday)

57

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Odd Jobs

11. BIRTHPLACE (State or foreign country)

Glasgow, Scotland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

219-07-0357

17. INFORMANT

ADDRESS

James McComb 1033 N. Milton Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of stomach

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

H. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Feb. 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Feb 21-1950

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

2224 N. Charles St

correct age is especially important. Physicians write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

FEB 20 1950

98895 500 1504

4613

CERTIFICATE OF DEATH

1925

James, John

11-17-1925

1925-11-17

1925-11-17

1925

1925

1925

235
50 1503McDaniels
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 59350 1503
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Minnie McDaniels</i>		2. DATE OF DEATH <i>Feb 18 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>225 Myrtle Ave</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>225 Myrtle Ave Balto Md</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>4-02</i> D. STREET ADDRESS (If rural, give location) <i>225 Myrtle Ave</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		5. SEX <i>Female</i> 6. COLOR OR RACE <i>Colored</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	
C. Length of stay in Baltimore		8. DATE OF BIRTH <i>1-3 1890</i> 9. AGE (In years, last birthday) <i>60</i> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>Abner Thomas</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i> 12. CITIZEN OF WHAT COUNTRY? <i>American</i> 14. MOTHER'S MAIDEN NAME <i>Rhodie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>George Goodson</i>		ADDRESS <i>225 Myrtle Ave</i>	

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Myocarditis with hyper-
(A) DUE TO *thrombosis*
INTERVAL BETWEEN ONSET AND DEATH
Sept 30, 49 to Feb 18, 50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

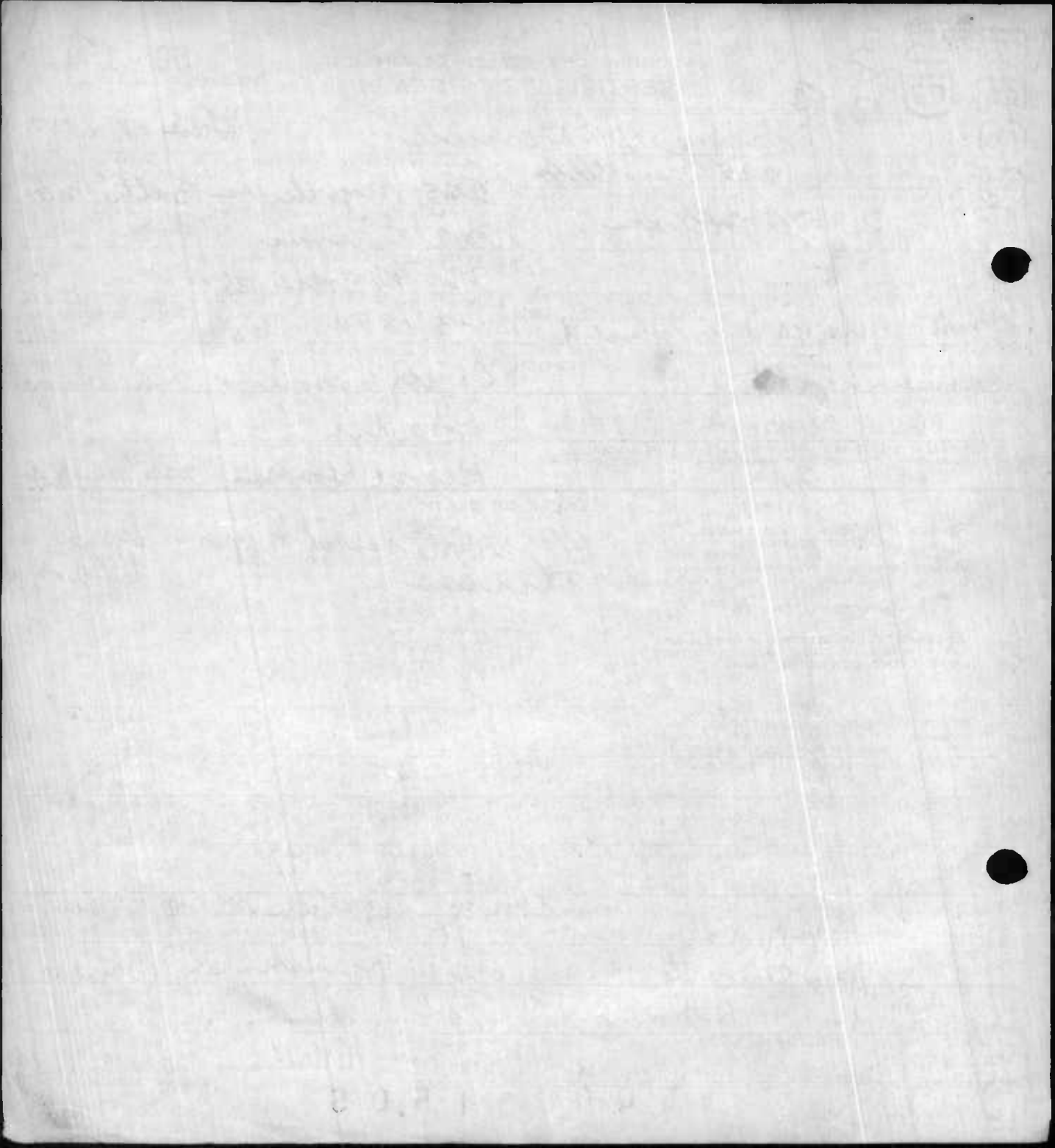
(C) DUE TO

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Sept 30*, 19*49* to *Feb 18*, 19*50* that I last saw the deceased alive on *Feb 17*, 19*50*, and that death occurred at *10* *PM* from the causes and on the date stated above.

23A. SIGNATURE *J. B. Stewart* M. D. 23B. ADDRESS *632 W. Frankish St* 23C. DATE SIGNED *Feb 20 50*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Shipped</i>		24B. DATE <i>2-20-1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Darlington, S. C.</i>		24D. LOCATION (City, town, or county) (State) <i>Darlington, S. C.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 20 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams</i>		25. FUNERAL DIRECTOR <i>Mrs. Katie R. Williams</i>		ADDRESS <i>322 N. Schneider St</i>	



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1504**

423
BIRTH NO. **50 1504**

1. NAME OF DECEASED (Type or Print) ELLIS ALSTON		2. DATE OF DEATH February 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 1022 Shields Place		E. Length of stay in Baltimore Yrs. Mos. Days	

5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Jan. 10, 1910	9. AGE (In years last birthday) 40	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rocky Mount N.C.	
13. FATHER'S NAME John Alston		14. MOTHER'S MAIDEN NAME Mary Richardson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Horace Sims	
				ADDRESS 212 N. Carey St.	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Lobar pneumonia (A) bilateral DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic alcoholism (C) DUE TO		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE H. J. Mc Clafferty		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 2-18-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb 21, 1950	24C. NAME OF CEMETERY OR CREMATORY mt. suburn	24D. LOCATION (City, town, or county) (State) Baltimore, Md		
DATE RECEIVED BY LOCAL REGISTRAR FEB 20 1950		REGISTRAR'S SIGNATURE Montgomery Williams		25. FUNERAL DIRECTOR Mrs. Kate P. Williams	
				ADDRESS Schweitzer St	

VS 151 **98899** **108**

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

1933

1934

1935

1936

1937

1938

1939

1940

1941

1942

1943

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

1505

BIRTH No. 1505

1. NAME OF DECEASED
(Type or Print)

Robey E. Armstrong

2. DATE
OF
DEATH

Feb. 18 - 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence

A. STATE

MD.

B. COUNTY

Baltimore

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

Rural Balto. 20

D. STREET ADDRESS (If rural, give location)

#5 Maxwell Rd.

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, OR SEPARATED (Specify)

Married

8. DATE OF BIRTH

June 26 - 1925

9. AGE (In years

last birthday) 24

If Under 1 Year

Months: Days: Hours: Min.

7 26

10A. USUAL OCCUPATION (Give kind of work in which most of working life, even if retired)

U.S. Gov.

10B. KIND OF BUSINESS OR INDUSTRY

Guard, Edg. Guard

11. BIRTHPLACE (State or foreign country)

Tazewell Co. Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Edward Armstrong

14. MOTHER'S MAIDEN NAME

Ida Mae Pruitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

Yes

W.W.#2

16. SOCIAL SECURITY NO.

17. INFORMANT

Charles P. Armstrong Sgt. Langley AFB Va.

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH
(A) Fracture of skull & intracranial hemorrhage
(B) ...
(C) ...

INTERVAL BETWEEN ONSET AND DEATH

19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Pulaski Highway & Ebenezer Rd., 53-00

Trillemarsh, Balto. Co.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Feb. 17, 1950 11:10 P.m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Auto into Auto

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Earl L. Boyer

M.D.

23B. CHIEF MEDICAL EXAMINER

23C. DATE SIGNED

19 Feb 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

2/20/50

24C. NAME OF CEMETERY OR CREMATORY

Riverside Cemetery

24D. LOCATION (City, town, or county)

Marion, Va

DATE RECEIVED BY LOCAL REGISTRAR

FEB 20 1950

REGISTRAR'S SIGNATURE

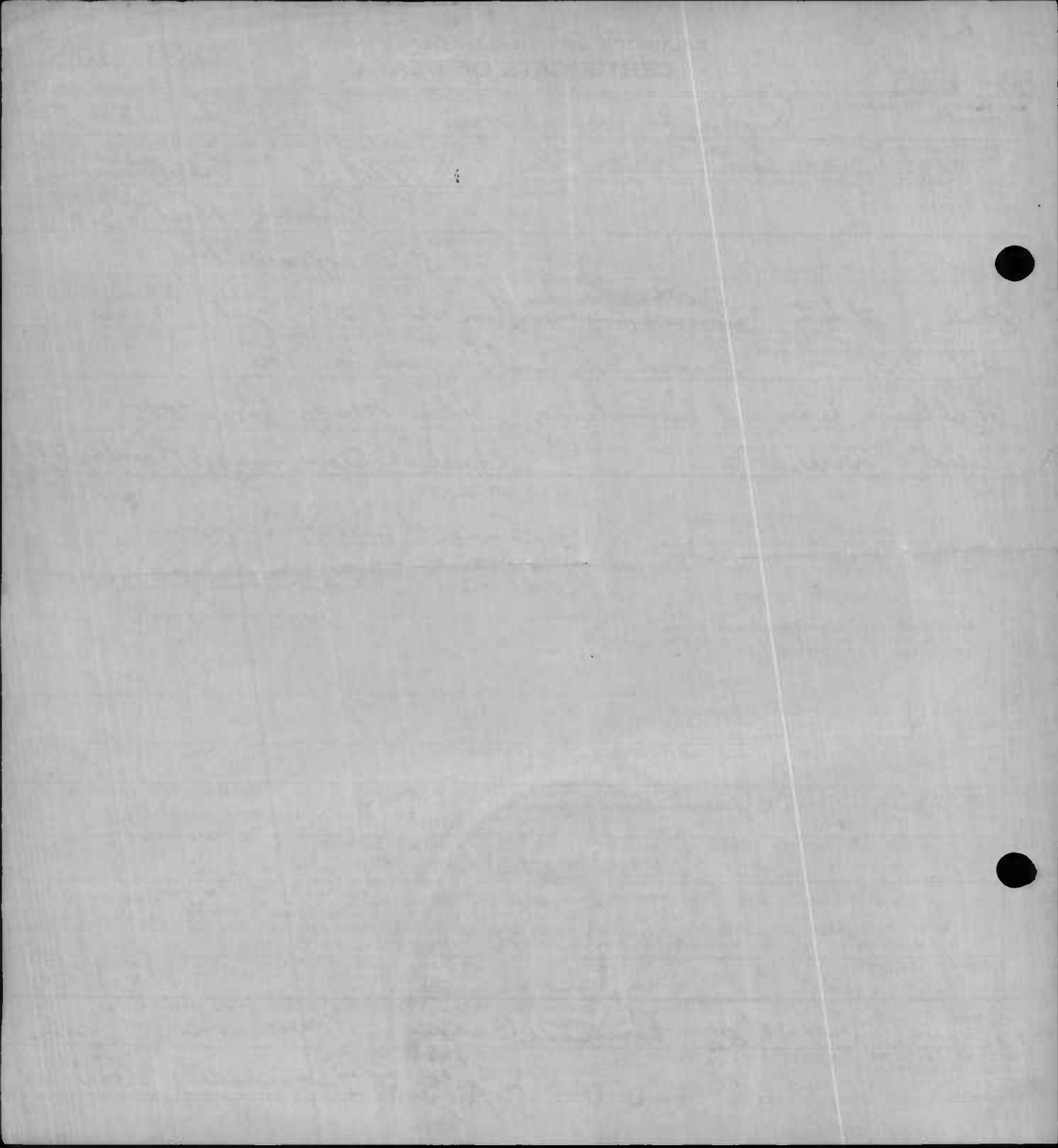
...

25. FUNERAL DIRECTOR

...

ADDRESS

...



50 1506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1506

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lucy Viola Kelley

2. DATE
OF
DEATH

Feb. 19/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1708 Eutaw Place

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Elmhurst Nursing Home

C. Length of stay in Baltimore

2yrs

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 29, 1887

9. AGE (In years

last birthday)

62

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Hancock Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Augustus Kerns

14. MOTHER'S MAIDEN NAME

Genevieve Mause

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mr. John Joseph Kelley, 727 N. Broadway

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebral Hemorrhage
Previous Cerebral Hemorrhage
Hypertension (at J. H. H.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

Atherosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

no

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 19 1949 to Feb. 19 1950, that I last saw the deceased alive on Feb. 19 1950, and that death occurred at 3 P m., from the causes and on the date stated above.

23A. SIGNATURE

Louis Jacob M.D.

23B. ADDRESS

1700 Eutaw Place Feb. 20-1950

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

Feb. 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

St. Peters & St. Pauls Cem.

24D. LOCATION (City, town, or county)

Cumberland Md.

(State)

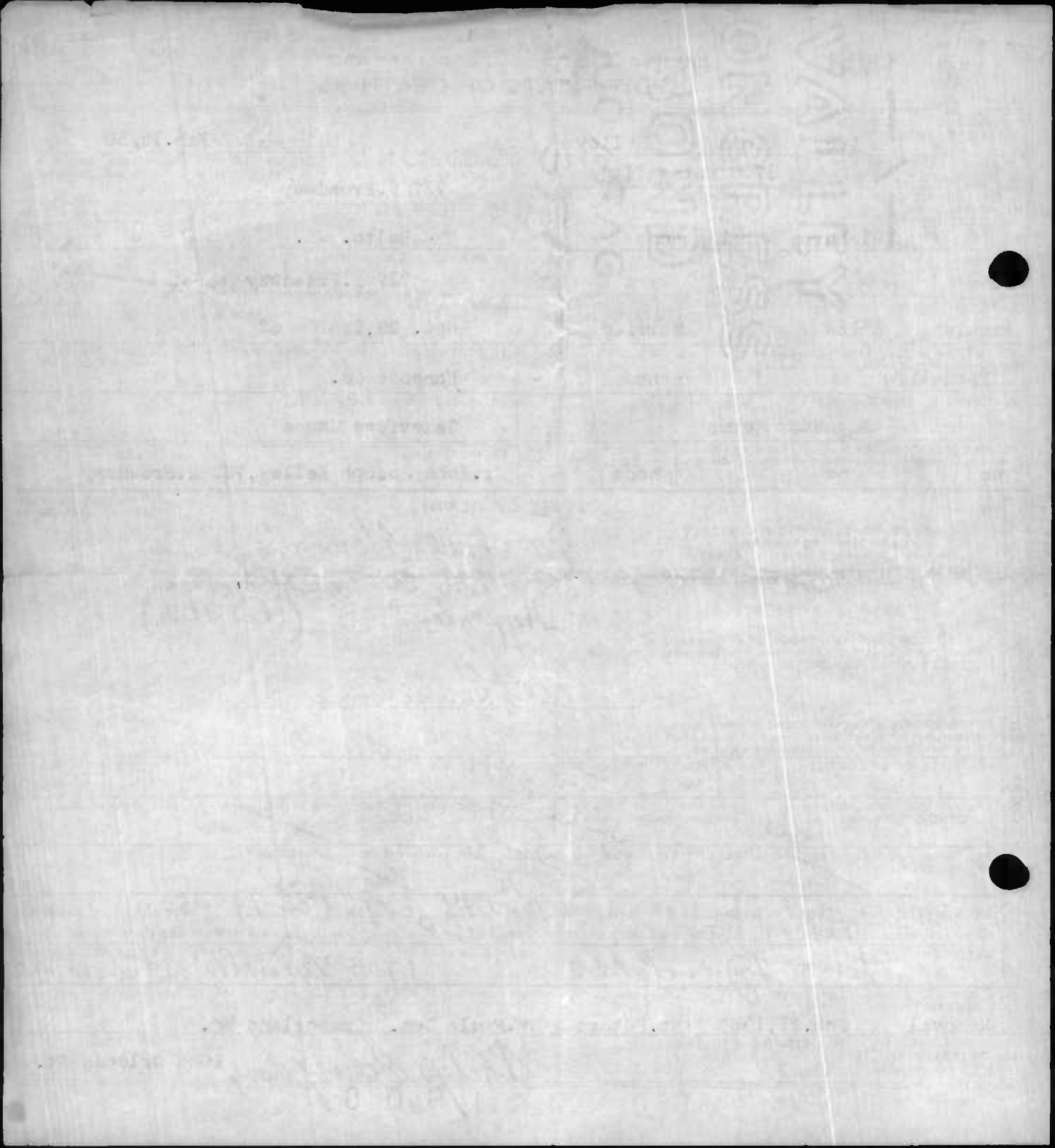
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

2024 Orleans St.



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BANKS
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Joseph Banks

2. DATE
OF
DEATH

2/19/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Ind. Gen. Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

COUNTY

820 Wheat coast st

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. Md

16-02

D. STREET ADDRESS (If rural, give location)

820 Wheat coast st

Length of stay in Baltimore

34 yrs.

Yrs.
Mos.
Days

5. SEX

m.

6. COLOR OR RACE

wh.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

1916

9. AGE (in years last birthday)

34 yrs.

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

unemployed

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

Franklin Banks

14. MOTHER'S MAIDEN NAME

Mary Charter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Helen Peterson 822 Wheat coast

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Diabetes Mellitus

DUE TO

acidosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

nausea

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *inquiry* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Earl L. Boyer

M.D.

23B. CHIEF MEDICAL EXAMINER ☐

23C. DATE SIGNED *19 Feb 50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/23/50

24C. NAME OF CEMETERY OR CREMATORY

St. Calvary

24D. LOCATION (City, town, or county)

A. F. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

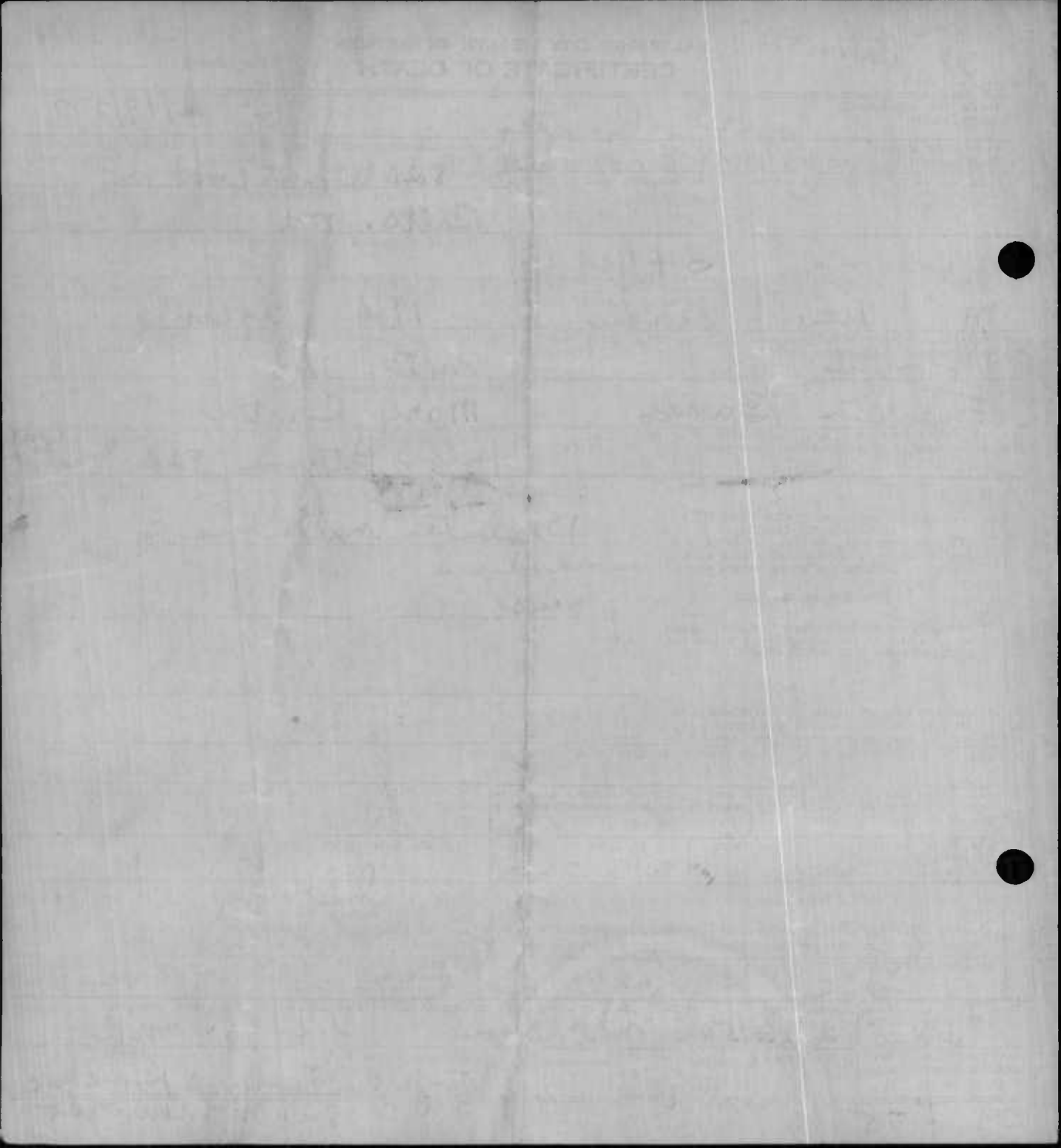
25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

Metropolitan Funeral Home Inc.

927 N. Mount St.



correct age is especially important. Physicians write the causes of death clearly and legibly.

400
50 1508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1508

BIRTH NO.

Registered No.

1. NAME OF DECEASED
(Type or Print)

BLANCHE GRAPE GILL

2. DATE
OF
DEATH

Feb. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

4 E. Biddle St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4 E. Biddle St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Feb. 11, 1882

9. AGE (In years
last birthday)

68

If Under 1 Year
Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Saleslady

10B. KIND OF BUSINESS OR
INDUSTRY

Read Drug & Chem. Co

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Grape

14. MOTHER'S MAIDEN NAME

Mary Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-59-7531

17. INFORMANT

ADDRESS

Mrs Lenore Gill, 3704 Kimble Road.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Acute Cardiac Distention

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Myocardial Insufficiency

(C)

Acute Bronchitis & Pulmonary

2 wks.

"

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from Jan - 1, 1950, to Feb - 18, 1950, that I last saw the deceased alive on Jan 10, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2/22/50

24C. NAME OF CEMETERY OR CREMATORY

Green Mount

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul St.

VS 150

29870 1500001510 1062

Foyell Milton

620
50 1509BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 470.0 50 1509

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARIE CLARE BRACE

2. DATE
OF
DEATH

2-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
Hosp. for the Women of Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 11-01

D. STREET ADDRESS (If rural, give location)

1001 St. Paul St.

C. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct. 22, 1879

9. AGE (In years
last birthday)

70

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Marshall Brace

11. BIRTHPLACE (State or foreign country)

Dunlap, Iowa

12. CITIZEN OF
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Lucy Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Patient

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

arteriosclerotic heart d.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Chronic Bronchitis with marked
Emphysema

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-7, 1950 to 2-20, 1950 that I last saw the
deceased alive on 2-20, 1950, and that death occurred at 1:55 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Wm. P. Benson, Jr. M.D.

23B. ADDRESS

Women's Hosp.

23C. DATE SIGNED

2-20-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

2/22/50

24C. NAME OF CEMETERY OR CREMATORY

Dunlap Iowa

24D. LOCATION (City, town, or county)

Dunlap Iowa

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc. 1217 St. Paul St.

VS 150

1950000151

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

1044-13-50
1879-10-22

70-3-28

635
50 1510BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1510
Registered No.

BIRTH NO. 48-19135

1. NAME OF DECEASED
(Type or Print)

Raymond Erding, Jr.

2. DATE
OF
DEATH

Feb. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

West Baltimore General Hospital

Yrs.
Mos.
Days

Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-16

D. STREET ADDRESS (If rural, give location)

3000 Rosalind Ave

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Aug. 4, 1948

9. AGE (In years
last birthday)

1

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Raymond Erding

14. MOTHER'S MAIDEN NAME

Mildred Hamilton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Hamilton, 3000 Roslyn Ave.

18. 571.0 I E 921.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Aspiration of vomitus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Acute gastro enteritis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

3000 Rosalind Ave.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Feb. 18, 1950 ? m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Aspiration of vomitus

22. I certify that I took charge of the remains described above, held an AUTOPSY thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER ☒

Feb. 20, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2/22/50

24C. NAME OF CEMETERY OR CREMATORY

Good Shephard

24D. LOCATION (City, town, or county)

Ellicott City, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

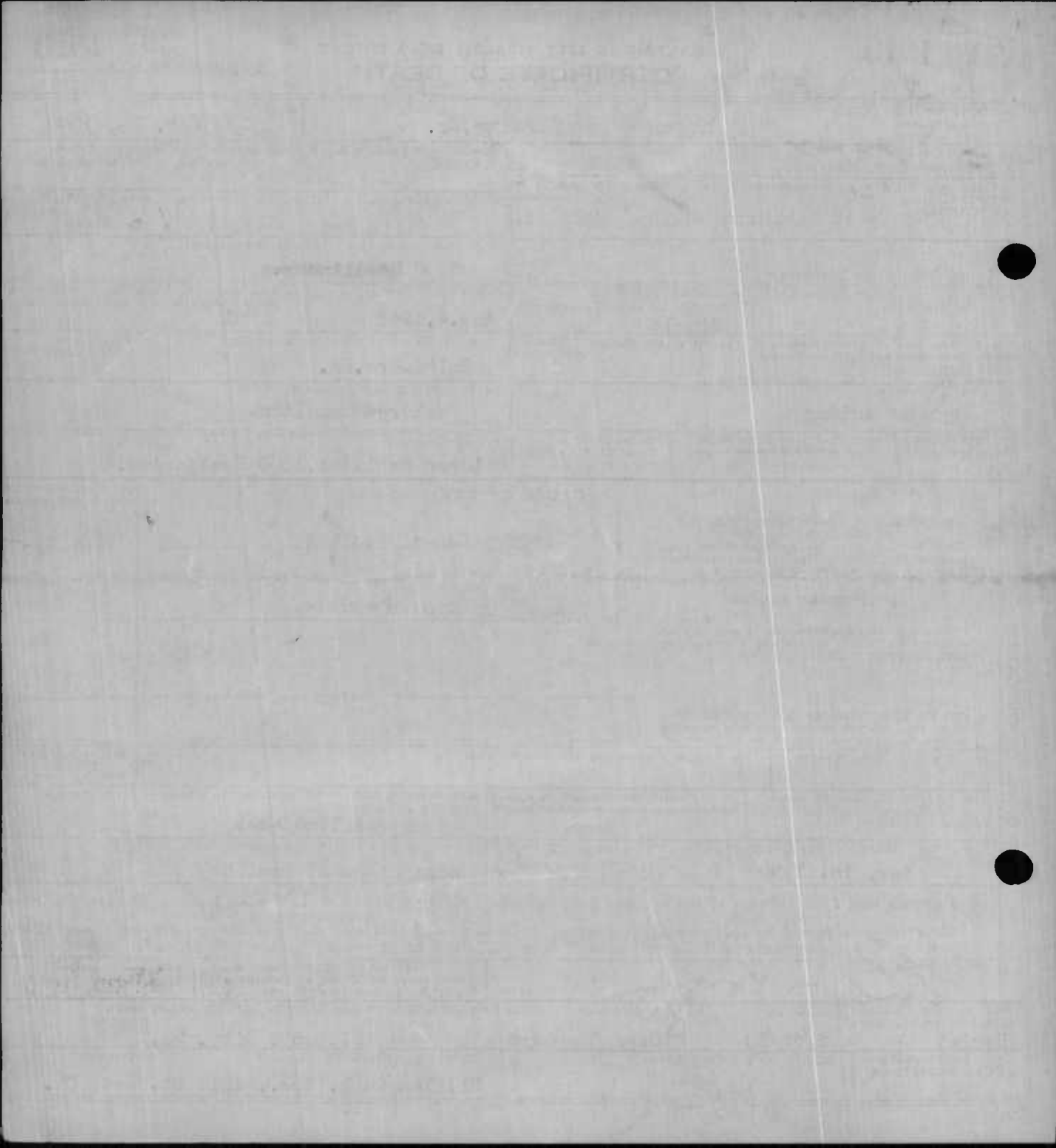
25. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul St.

VS 151

119a



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

50 1511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1511

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Essie Mae Davis</i>		2. DATE OF DEATH <i>2-16-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>City</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore <i>15 Yrs. Mos. Days</i>		D. STREET ADDRESS (If rural, give location) <i>575- Biddle St. W.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Mar. 21/1912</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>maid</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>	9. AGE (in years last birthday) <i>37</i>
11. BIRTHPLACE (State or foreign country) <i>Norfolk Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nelson Willaford</i>		14. MOTHER'S MAIDEN NAME <i>Ida ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no none</i>		16. SOCIAL SECURITY NO. <i>214-12-4452</i>	
17. INFORMANT <i>Robt. Johnson</i>		ADDRESS <i>Biddle St.</i>	

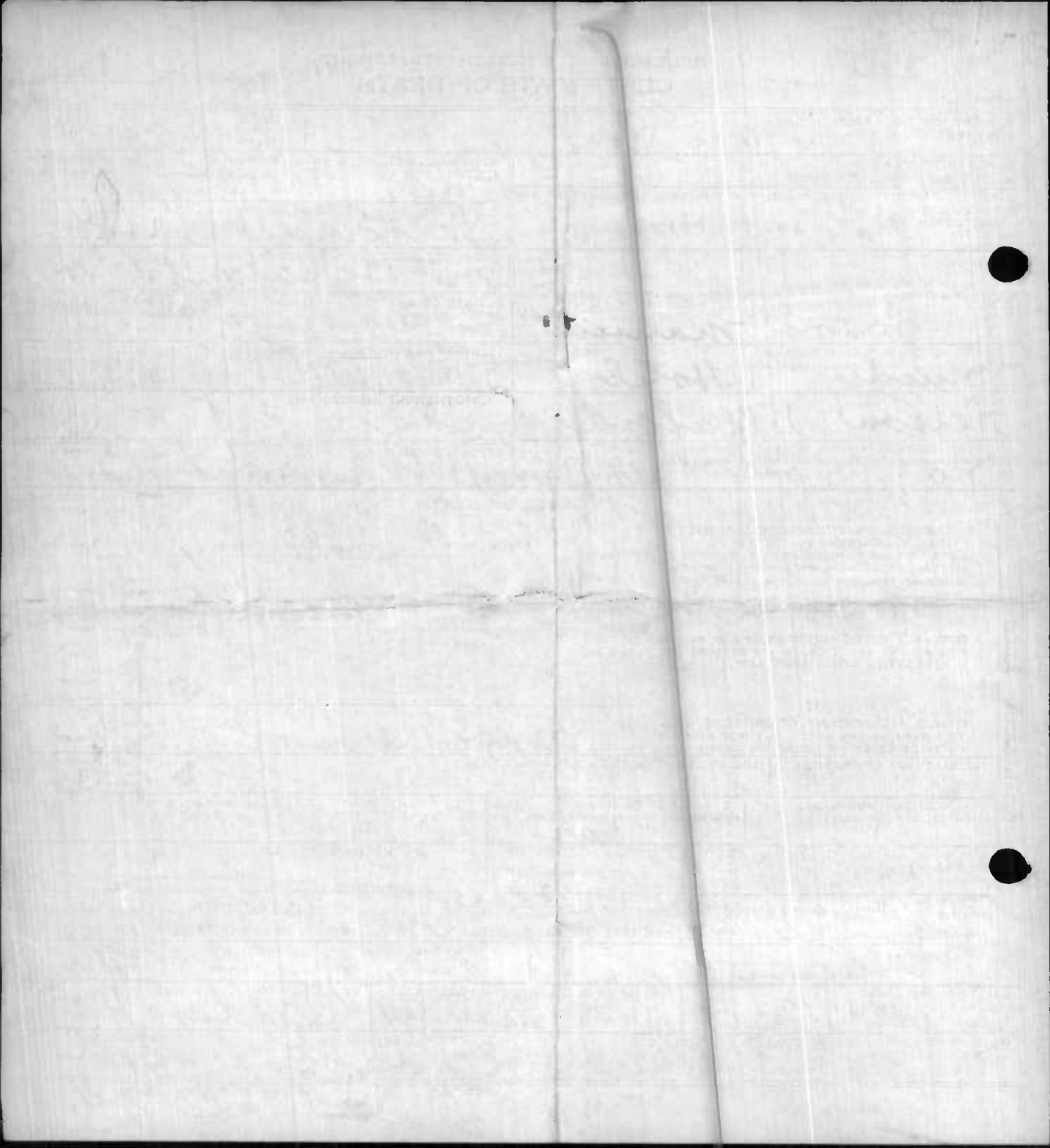
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Renal insufficiency</i>		<i>Undet.</i>
DUE TO (A)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Pos. Chronic glomerulonephritis</i>		<i>Undet.</i>
DUE TO (B)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>congestive heart failure</i>		<i>Undet.</i>
DUE TO (C)		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>2/8/50</i> , 19 <i>50</i> , to <i>2/16/50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>2/16</i> , 19 <i>50</i> , and that death occurred at <i>9:30</i> a.m., from the causes and on the date stated above.				
23A. SIGNATURE <i>Lucius W. Jones M.D.</i>		23B. ADDRESS <i>Provident Hosp.</i>		23C. DATE SIGNED <i>Feb. 17, 1950</i>

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2/23/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 21 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston</i>	
25. FUNERAL DIRECTOR <i>A. Halstead</i>		ADDRESS <i>918- ...</i>	

VS 150

77087 1459312 Alice D. Still Ave.



263
50 1512

BALTIMORE CITY HEALTH DEPARTMENT 490 50 1512

CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or print) *Anna Richardson*

2. DATE OF DEATH *2/18/50*

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE *md.* B. COUNTY *City*

5. FULL NAME OF (If not in hospital or institution, give street address or location)
401 N. Calhoun St.

6. LENGTH OF STAY IN BALTIMORE *20* Yrs. *00* Mos. *00* Days

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Widow*

8. DATE OF BIRTH *-1894*

9. AGE (In years last birthday) *55*

10. USUAL OCCUPATION (Give last one during most of working life, even if retired) *Housewife*

10b. KIND OF BUSINESS OR INDUSTRY *own home*

11. BIRTHPLACE (State or foreign country) *N. C.*

12. CITIZEN OF WHAT COUNTRY? *U.S.A.*

13. FATHER'S NAME *unknown.*

14. MOTHER'S MAIDEN NAME *unknown*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) *no* (If yes, give war or dates of service) *none*

16. SOCIAL SECURITY NO. *none*

17. INFORMANT *Arthur Pierre - Calhoun St.*

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) *Lobar Pneumonia*
DUE TO
INTERVAL BETWEEN ONSET AND DEATH *2 wks*
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

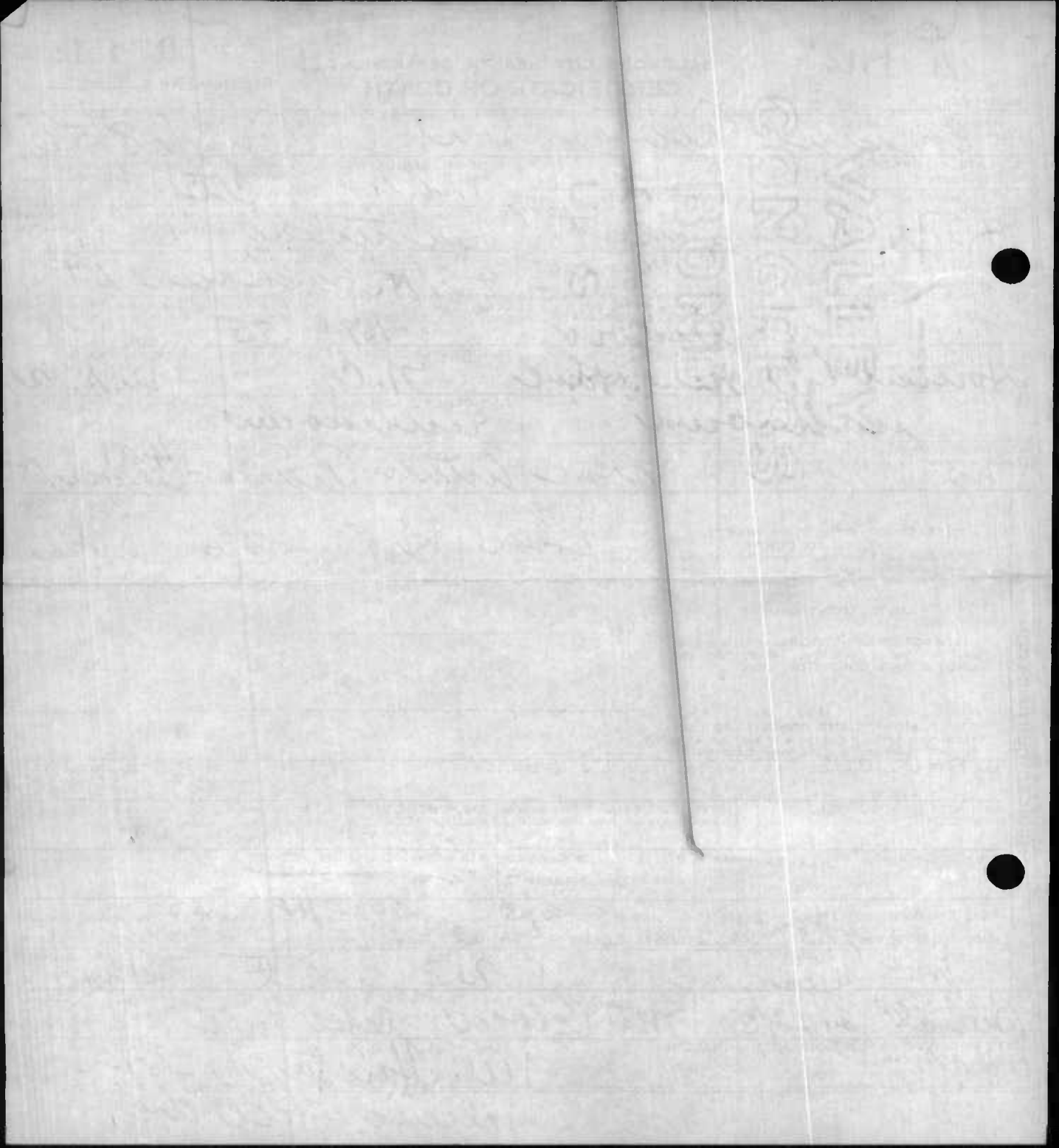
22. I hereby certify that I attended the deceased from *2/5* to *2/12*, 19*50*, that I last saw the deceased alive on *2/18*, 19*50*, and that death occurred at *2:30* p.m., from the causes and on the date stated above.

23a. SIGNATURE *W. C. Gump* M. D.
23b. ADDRESS *23 Gump St*
23c. DATE SIGNED *2/20/50*

24a. BURIAL, CREMATION, REMOVAL (Specify) *Burial*
24b. DATE *2/22/50*
24c. NAME OF CEMETERY OR CREMATORY *Mt. Calvary*
24d. LOCATION (City, town, or county) (State) *Cedar Hill Md*

DATE RECEIVED BY LOCAL REGISTRAR *FEB 21 1950*
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR *A. Halstead - 918 -*
ADDRESS *Linwood Hill ave,*

VS 150



5-163
50 1513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 331

50 1513
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JENNIE SPEERT

2. DATE
OF
DEATH

2-20-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2310 Whittier Ave

c. Length of stay in Baltimore

52 Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

a. STATE

Md

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 13-04

d. STREET ADDRESS (If rural, give location)

2310 Whittier Ave

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

9. AGE (In years last birthday)

72

10. Under 1 Year

Months: Days Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Not known

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Benjamin Speert 2310 Whittier Ave

18.

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

6 wks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

None

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940 to 2-20-1950, that I last saw the deceased alive on 2-20-1950, and that death occurred at 2:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE

D. L. Linn

23b. ADDRESS

2300 Easton Place

23c. DATE SIGNED

2-20-50

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

2-21-50

24c. NAME OF CEMETERY OR CREMATORY

Hebrew Mt Cemetery

24d. LOCATION (City, town, or county) (State)

Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. L. Linn

25. FUNERAL DIRECTOR

J. L. Linn 2100 Easton Pl

ADDRESS

2722

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1514 Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Gross, Sol / Sol. Gross

2. DATE
OF
DEATH

20 Feb 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

West Balto General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-09

D. STREET ADDRESS (If rural, give location)

4108 Norfolk Ave

Length of stay in Baltimore

50

Yrs.
Mons.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Business Agent

10B. KIND OF BUSINESS OR INDUSTRY

General

8. DATE OF BIRTH

9. AGE (In years last birthday)

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

30

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Aaron

14. MOTHER'S MAIDEN NAME

Rachael

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Sora Gross 4108 Norfolk Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cor pulmonale

2 weeks

II
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Bronchial asthma

yr

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Emphysema, old pulm Tbc

yr

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 16 Feb, 1950, to 20 Feb, 1950, that I last saw the deceased alive on 20 Feb, 1950, and that death occurred at 10:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

West Balto Gen Hosp

20 Feb 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Survival

2-22-50

Rosedale

Balto

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

Washington Williams, M.D.

Jack Lewicki 2100 Canton Pl

VS 150

20063 500001516 112

534
50 1515BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH331
50 1515
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EMANUEL E. RANDEL

2. DATE
OF
DEATH

FEB. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2545 West Baltimore Street

C. Length of stay in Baltimore 50 yrs.

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE CITY 20-04

D. STREET ADDRESS (If rural, give location)

2545 WEST BALTIMORE STREET

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
MARRIED

8. DATE OF BIRTH

10/29/1866

9. AGE (in years
last birthday)

83

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Time-Keeper .. Continental Can Co.

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

HENRY S. RANDEL

11. BIRTHPLACE (State or foreign country)

York, Pa.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

14. MOTHER'S MAIDEN NAME

SARAH ROSTETTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

(218-07-2975)

17. INFORMANT

ADDRESS

(A) Lottie G. Randel.....(same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

2/11 to 2/17/50

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

Arterial Sclerosis

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/11, 1950, to 2/17, 1950, that I last saw the
deceased alive on 2/17, 1950, and that death occurred at 7:15 P.M. from the causes and on the date stated above.

23A. SIGNATURE

Charles E. Kahn

M. D.

23B. ADDRESS

2145 W. Baltimore Street

23C. DATE SIGNED

2/1/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

BURIAL

24B. DATE

FEB. 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

LORRAINE PARK CEM.

24D. LOCATION (City, town, or county)

WOODLAWN Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

J. B. Ruppert & Son

ADDRESS

VS 150

2663V

83a

1100 Eastwood Rd - 7
17

No. 2456

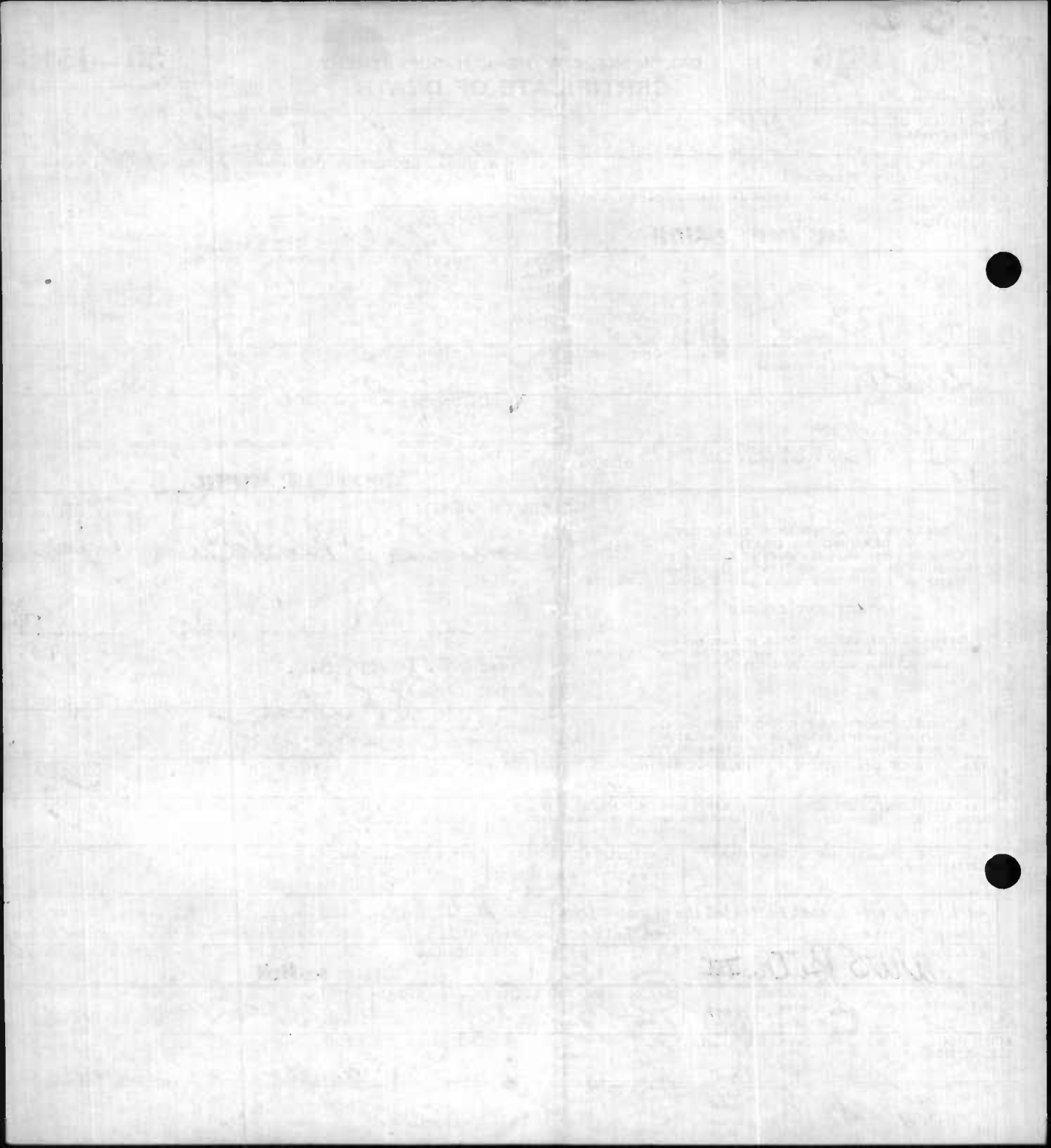
652
50 1516
BIRTH NO. *D.O. A*

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH *181*

Registered No. *50 1516*

1. NAME OF DECEASED (Type or Print) <i>Clarence Cornish</i>		2. DATE OF DEATH <i>Feb. 12, 1950</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Md</i> b. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 7-05</i>	
5. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <i>1642 C. Monument St</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1-6-95</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>55</i>
13. FATHER'S NAME <i>Arnon</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of bladder</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
DUE TO (A)			
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)			
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C)			
19a. DATE OF OPERATION <i>2</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>009</i> , 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at <i>1145</i> m., from the causes and on the date stated above.			
23a. SIGNATURE <i>WWS Butler</i>		23b. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>Feb 21, 1950</i>	
24c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary</i>		24d. LOCATION (City, town, or county) (State) <i>Leaw Hill Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 21 1950</i>		REGISTRAR'S SIGNATURE <i>Washington Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>Mr. Katie R. Williams</i>		ADDRESS <i>3224 Schuler St</i>	

VS 150
9899 Med. Ex. Case To be approved 52B



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

RICHARD JOHN WHITE

2. DATE
OF
DEATH

Feb. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION
US Marine Hospital
Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **NY** B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Huntington

D. STREET ADDRESS (If rural, give location)
62 Woodbury Road

5. Length of stay in Baltimore **46 days**

Yrs.
Mos.
Days

5. SEX
M

6. COLOR OR RACE
W

7. SINGLE, MARRIED, DIVORCED, WIDOWED (Specify)
MARRIED

8. DATE OF BIRTH
9/19/83

9. AGE (In years last birthday) **66**
If Under 1 Year: Months: Days: If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired

10B. KIND OF BUSINESS OR INDUSTRY
Lighthouse keeper

11. BIRTHPLACE (State or foreign country)
Mass.

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME

Thomas White

14. MOTHER'S MAIDEN NAME
Julia Crowley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Unknown

16. SOCIAL SECURITY NO.
None

17. INFORMANT ADDRESS
Records- US Marine Hospital, Balto, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Squamous cell carcinoma of right tonsil with ulceration and necrosis of epiglottis, pharynx and posterior tongue.**

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Pneumonia, lobular, bilateral, terminal**

Few days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 4**, 1950, to **Feb. 19**, 1950, that I last saw the deceased alive on **Feb. 19, 1950** and that death occurred at **4:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE
John L. Wilson, Medical Director

23B. ADDRESS
US Marine Hospital, Balto, Md.

23C. DATE SIGNED
2/20/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE
2/22/50

24C. NAME OF CEMETERY OR CREMATORY
Lorraine Cem.

24D. LOCATION (City, town, or county) (State)
Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

Huntington Williams, Jr.

WM. J. TICKNER & SONS Balto., Md.

VS 150

49697

45F

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Occupation		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Informant		13. Signature of Medical Officer		14. Signature of Coroner		15. Signature of Jury	
16. Signature of Minister of Health		17. Signature of Mayor		18. Signature of Council		19. Signature of Board of Health		20. Signature of Board of Police	
21. Signature of Board of Education		22. Signature of Board of Trade		23. Signature of Board of Fire		24. Signature of Board of Water		25. Signature of Board of Sewerage	
26. Signature of Board of Public Works		27. Signature of Board of Public Safety		28. Signature of Board of Public Health		29. Signature of Board of Public Education		30. Signature of Board of Public Welfare	
31. Signature of Board of Public Assistance		32. Signature of Board of Public Charities		33. Signature of Board of Public Relief		34. Signature of Board of Public Aid		35. Signature of Board of Public Support	
36. Signature of Board of Public Maintenance		37. Signature of Board of Public Conservation		38. Signature of Board of Public Preservation		39. Signature of Board of Public Protection		40. Signature of Board of Public Security	
41. Signature of Board of Public Defense		42. Signature of Board of Public Justice		43. Signature of Board of Public Order		44. Signature of Board of Public Peace		45. Signature of Board of Public Harmony	
46. Signature of Board of Public Unity		47. Signature of Board of Public Fellowship		48. Signature of Board of Public Brotherhood		49. Signature of Board of Public Sisterhood		50. Signature of Board of Public Love	
51. Signature of Board of Public Kindness		52. Signature of Board of Public Gentleness		53. Signature of Board of Public Meekness		54. Signature of Board of Public Patience		55. Signature of Board of Public Self-Control	
56. Signature of Board of Public Temperance		57. Signature of Board of Public Moderation		58. Signature of Board of Public Sobriety		59. Signature of Board of Public Cleanliness		60. Signature of Board of Public Decency	
61. Signature of Board of Public Propriety		62. Signature of Board of Public Virtue		63. Signature of Board of Public Honor		64. Signature of Board of Public Integrity		65. Signature of Board of Public Trustworthiness	
66. Signature of Board of Public Reliability		67. Signature of Board of Public Faithfulness		68. Signature of Board of Public Loyalty		69. Signature of Board of Public Obedience		70. Signature of Board of Public Respect	
71. Signature of Board of Public Reverence		72. Signature of Board of Public Dignity		73. Signature of Board of Public Grace		74. Signature of Board of Public Mercy		75. Signature of Board of Public Compassion	
76. Signature of Board of Public Kindness		77. Signature of Board of Public Gentleness		78. Signature of Board of Public Meekness		79. Signature of Board of Public Patience		80. Signature of Board of Public Self-Control	
81. Signature of Board of Public Temperance		82. Signature of Board of Public Moderation		83. Signature of Board of Public Sobriety		84. Signature of Board of Public Cleanliness		85. Signature of Board of Public Decency	
86. Signature of Board of Public Propriety		87. Signature of Board of Public Virtue		88. Signature of Board of Public Honor		89. Signature of Board of Public Integrity		90. Signature of Board of Public Trustworthiness	
91. Signature of Board of Public Reliability		92. Signature of Board of Public Faithfulness		93. Signature of Board of Public Loyalty		94. Signature of Board of Public Obedience		95. Signature of Board of Public Respect	
96. Signature of Board of Public Reverence		97. Signature of Board of Public Dignity		98. Signature of Board of Public Grace		99. Signature of Board of Public Mercy		100. Signature of Board of Public Compassion	

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1518
Registered No. 50 1518

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD M. TENNEY, Jr.		2. DATE OF DEATH February 20, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-03	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 225 E. 25th Street	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED (Specify)	8. DATE OF BIRTH April 19, 1905 44
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Importer (Own)		10B. KIND OF BUSINESS OR INDUSTRY Importing	
11. BIRTHPLACE (State or foreign country) Edgemont, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Tenney		14. MOTHER'S MAIDEN NAME Mary Stauffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) yes World War II		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Margaret F. Tenney		ADDRESS 225 E. 25th St.	

18. CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary artery disease DUE TO	
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE R. S. Fisher M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 2-20-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 2/23/50

24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.

24D. LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS

ADDRESS Balto., Md.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 470.1

BIRTH NO. 400
50 1519

1. NAME OF DECEASED (Type or Print) OSWALD			2. DATE OF DEATH February 20, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Virginia B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Newport News		
D. Length of stay in Baltimore _____ Yrs. Mos. Days			E. STREET ADDRESS (If rural, give location) 1000 Temple Lane		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 26, 1901		9. AGE (In years last birthday) 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President			10B. KIND OF BUSINESS OR INDUSTRY Floor Covering		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? ---			13. FATHER'S NAME John Tall		
14. MOTHER'S MAIDEN NAME ---			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. ---			17. INFORMANT ADDRESS Mr. Le Roy Tall 2407 Baker St.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary artery disease (A) _____ DUE TO _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) _____		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE R. S. Fisher M.D. 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED 2-20-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 2/23/50 24C. NAME OF CEMETERY OR CREMATORY Woodlawn 24D. LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR FEB 21 1950 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR WM. J. STICKNER & SONS ADDRESS Balto., Md.

VS 151 - 15602

94a



Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

NATIONAL CITY HEALTH DEPARTMENT

Form No. 1

Revised 1934

City of New York

County of New York

State of New York

Death of

Name of Deceased

Age

Sex

Race

Religion

Marital Status

Occupation

Place of Birth

Date of Death

Time of Death

Place of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Witness

Signature of Deceased

Signature of Family

Signature of Neighbor

Signature of Minister

Signature of Priest

Signature of Rabbi

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1520
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

GENERAL MARION DEEMS

2. DATE OF DEATH
Feb. 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY _____

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE **4017 Parkside Drive**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore -6 27-01

Length of stay in Baltimore **Life**
Yrs. _____
Mos. _____
Days _____

D. STREET ADDRESS (If rural, give location)
4017 Parkside Drive

5. SEX **Male**
6. COLOR OR RACE **White**
7. SINGLE, MARRIED, **Married**
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH **Apr. 30, 1885**
9. AGE (in years last birthday) **64 yrs**
If Under 1 Year Months: Days _____
If Under 24 Hours Hours: Min. _____

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Steamfitter
10B. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) **Baltimore Md.**
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME
Charles Deems

14. MOTHER'S MAIDEN NAME
Margaret Myers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
no
16. SOCIAL SECURITY NO. **312-14-0417**

17. INFORMANT ADDRESS
Rose E. Deems (Wife) 4017 Parkside Dr.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Coronary occlusion**
DUE TO **sclerosis**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Coronary Sclerosis, Cerebral**
DUE TO **mild Hypertension**
(C) **Benign Prostatic Hypertrophy**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Benign Prostatic Hypertrophy

19A. DATE OF OPERATION **Aug. - 1949**
19B. MAJOR FINDINGS OF OPERATION **Benign enlargement of prostate**
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

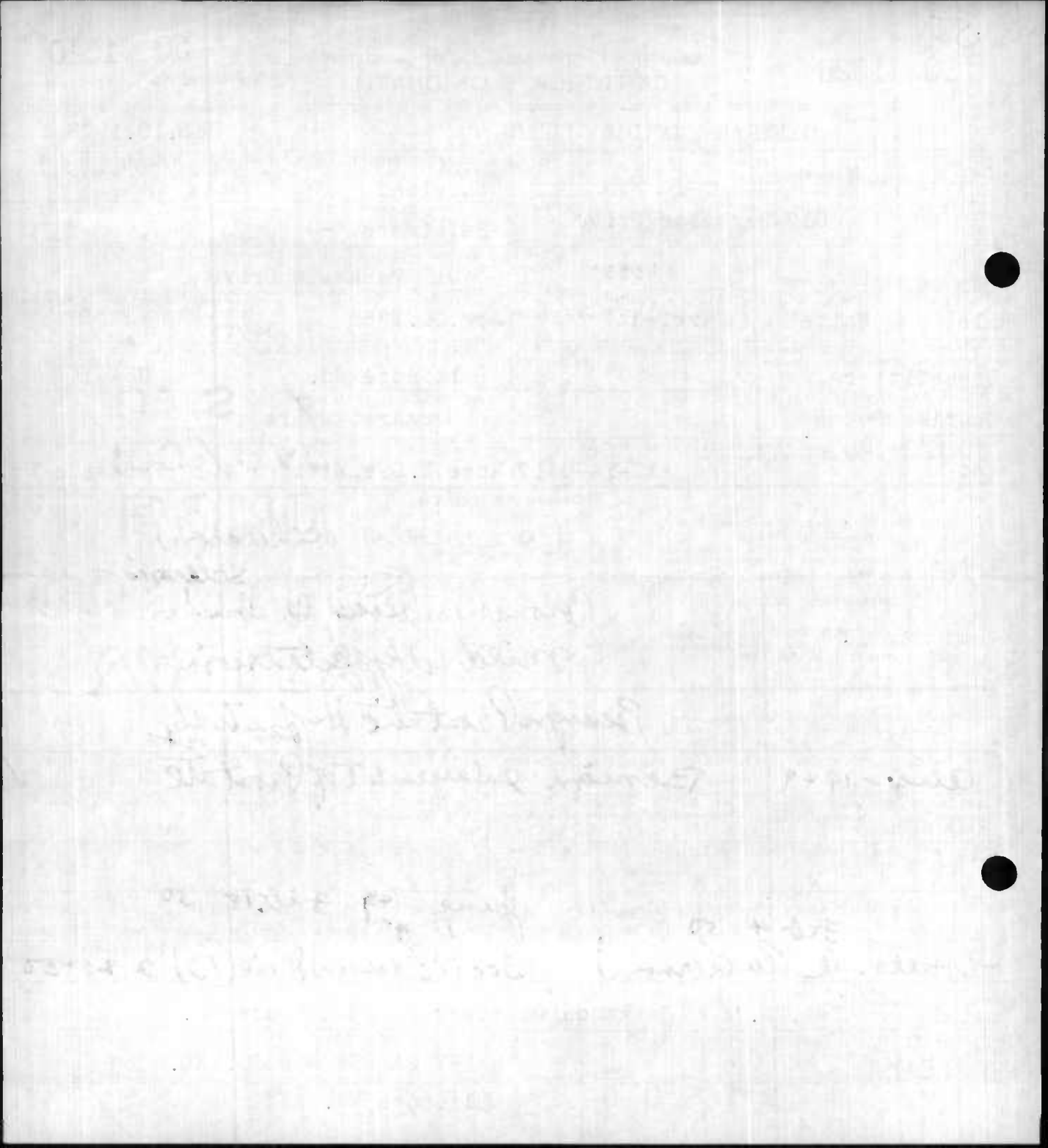
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **June, 1949** to **Feb. 18, 1950**, that I last saw the deceased alive on **Feb 4, 1950**, and that death occurred at **11 AM.**, from the causes and on the date stated above.

23A. SIGNATURE **Charles A. Anderson**
M. D. **3001 Shannon Drive (13)**
23B. ADDRESS **270-50**
23C. DATE SIGNED **2-20-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**
24B. DATE **Feb. 22, '50**
24C. NAME OF CEMETERY OR CREMATORY **Parkwood Cemetery**
24D. LOCATION (City, town, or county) (State) **Baltimore Md.**

DATE RECEIVED BY LOCAL REGISTRAR **FEB 21 1950**
REGISTRAR'S SIGNATURE **William Williams**
25. FUNERAL DIRECTOR ADDRESS **HENRY SANDER & SONS, INC.**



STATE OF TEXAS
COUNTY OF DALLAS

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at Dallas, Texas, this 1st day of May, 1901.

CLERK

WITNESSES my hand and the seal of said County, at Dallas, Texas, this 1st day of May, 1901.

NOTARY PUBLIC

NOTARY PUBLIC

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 491

Registered No.

50 1522

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

2/18/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

615 N. Central Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore City

5-01

D. STREET ADDRESS (If rural, give location)

615 N. Central Ave

Length of stay in Baltimore

7 Yrs.

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Driller

10B. KIND OF BUSINESS OR
INDUSTRY

Ship Yard

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Pearl White 615 N. Central Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Bronchial Pneumonia

12 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

Colds & Exposure

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 2-6-50, to 2-18-50, that I last saw the
deceased alive on 2-18-50, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

Elroy O. Wilson 1000 Brantly

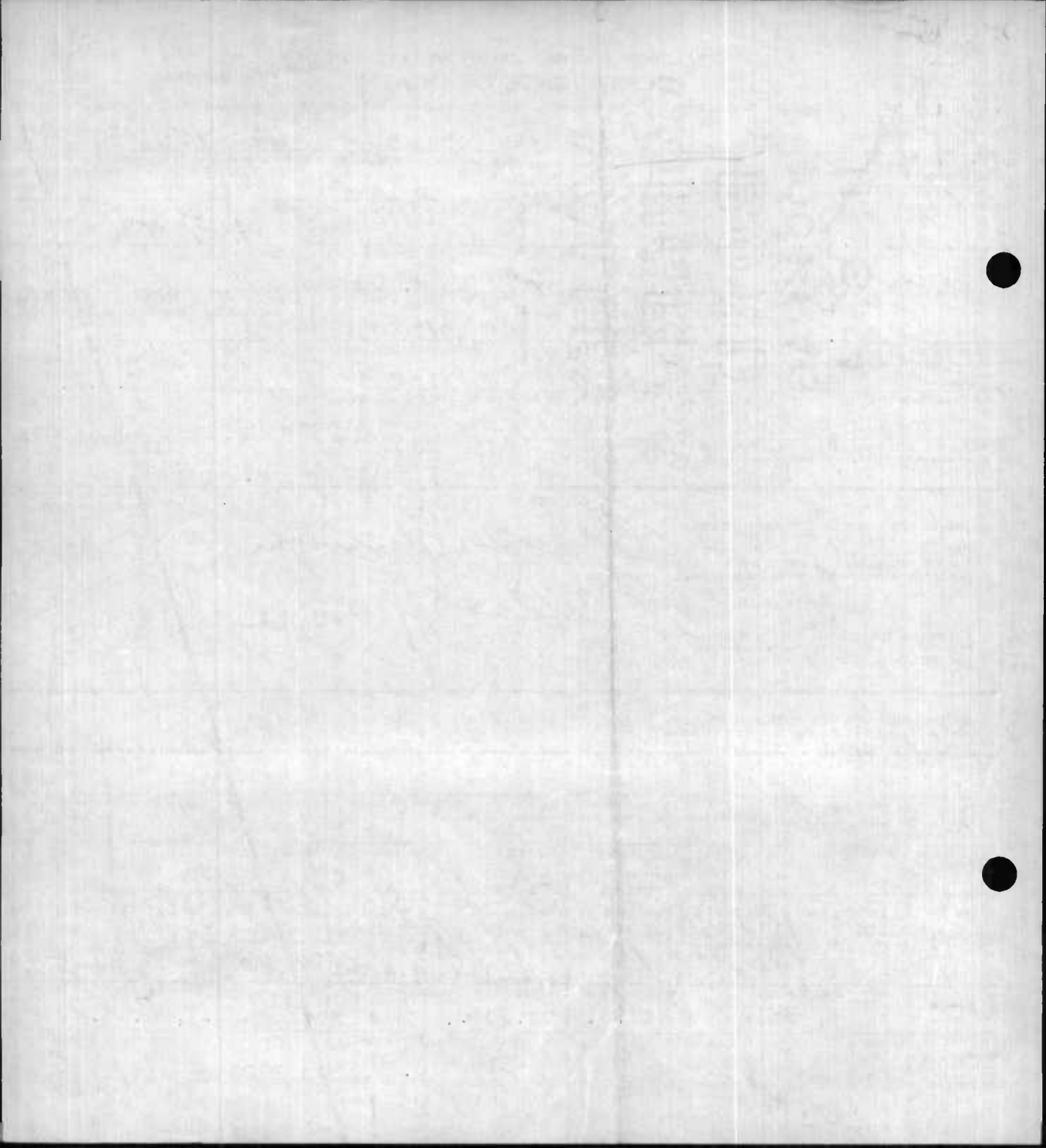
VS 150

496 4V

01524

107

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

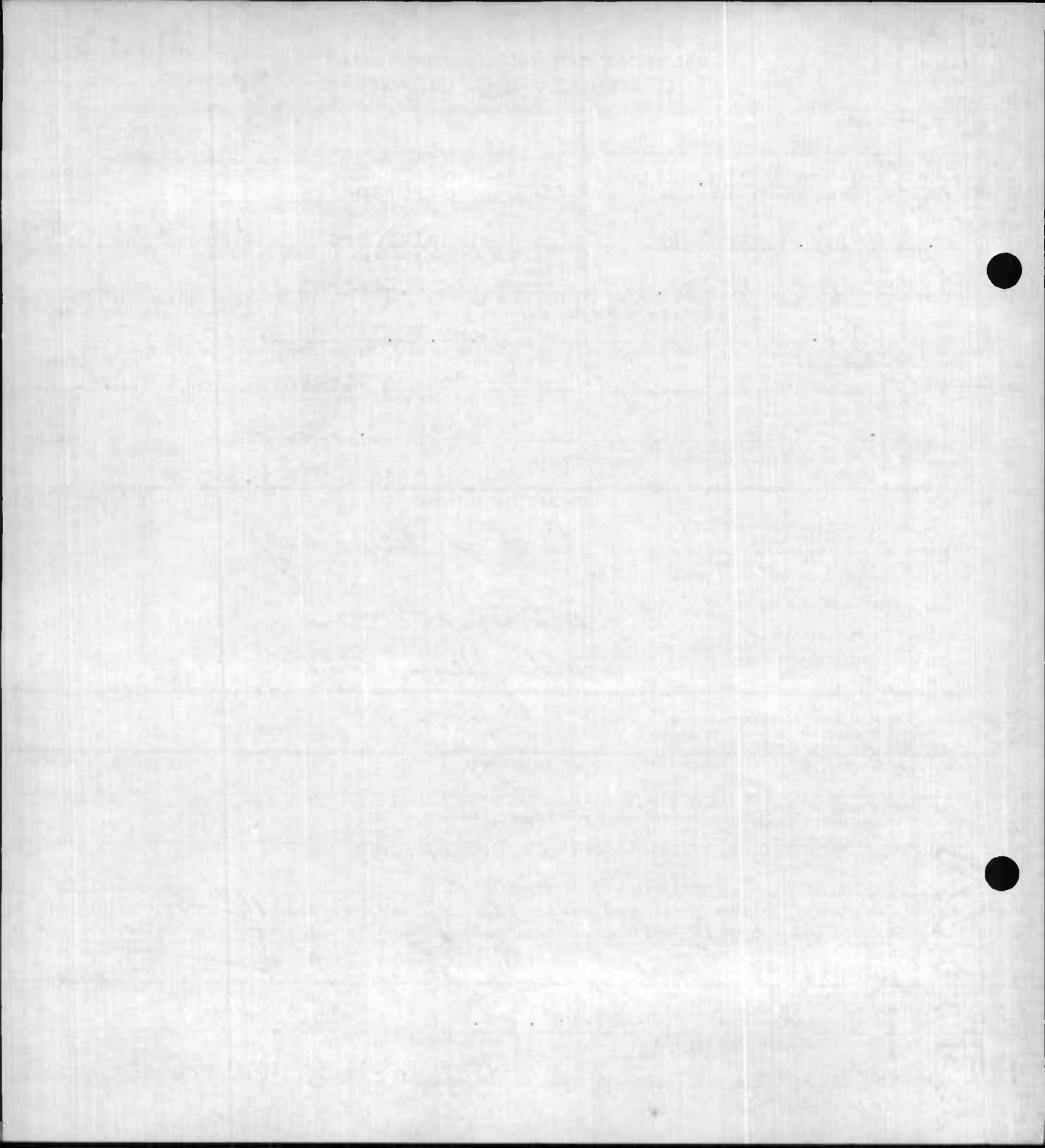
1. NAME OF DECEASED (Type or Print) Ralph Thomas		2. DATE OF DEATH 2/18/1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 713 N. Central Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 713 N. Central Ave		E. AGE (In years last birthday) 57 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.	
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 12, 1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed LABORER		11. BIRTHPLACE (State or foreign country) Hodson Virginia	
13. FATHER'S NAME John H. Thomas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) War # I		16. SOCIAL SECURITY NO. _____	
17. INFORMANT John Thomas		ADDRESS 714 N. Gay St	

CAUSE OF DEATH

<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p align="center">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>
<p>(A) Cerebral hemorrhage DUE TO</p> <p>(B) Arterio sclerosis DUE TO</p> <p>(C) old Hemiplegia '27</p>	
<p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from Dec 16, 1947, to Feb 16, 1950, that I last saw the deceased alive on Feb 16, 1950, and that death occurred at 4 A.M., from the causes and on the date stated above.</p>					
23A. SIGNATURE Morris C. Jone		23B. ADDRESS 118 Biquik St		23C. DATE SIGNED 2/20/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/23/1950		24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	

DATE RECEIVED BY LOCAL REGISTRAR FEB 21 1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR Elroy O. Wilson	
				ADDRESS 1000 Brantly Ave	



514
50 1524

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1524

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sadie Gamble

2. DATE

OF DEATH 2/17/1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland Balto. City

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
832 South Eutaw Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore City 22-02

d. STREET ADDRESS (If rural, give location)

832 South Eutaw Street

Length of stay in Baltimore 9 Yrs.

5. SEX

Female

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

3/1/1912

9. AGE (In years last birthday)

37

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Maid

10b. KIND OF BUSINESS OR INDUSTRY
Gas & Electric

11. BIRTHPLACE (State or foreign country)

Johnsville S.C.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Bunzel Hanna

14. MOTHER'S MAIDEN NAME

Lena Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mildred Gass Cho 1633 W. Lex. St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cardio Vascular Disease 6 mo

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-4, 1930 to 2-17, 1930 that I last saw the deceased alive on 2-15, 1930 and that death occurred at m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

Burial

2/23/1950

Mt Calvary Cem.

Brooklyn A.A.Co.Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

Thurston Williams

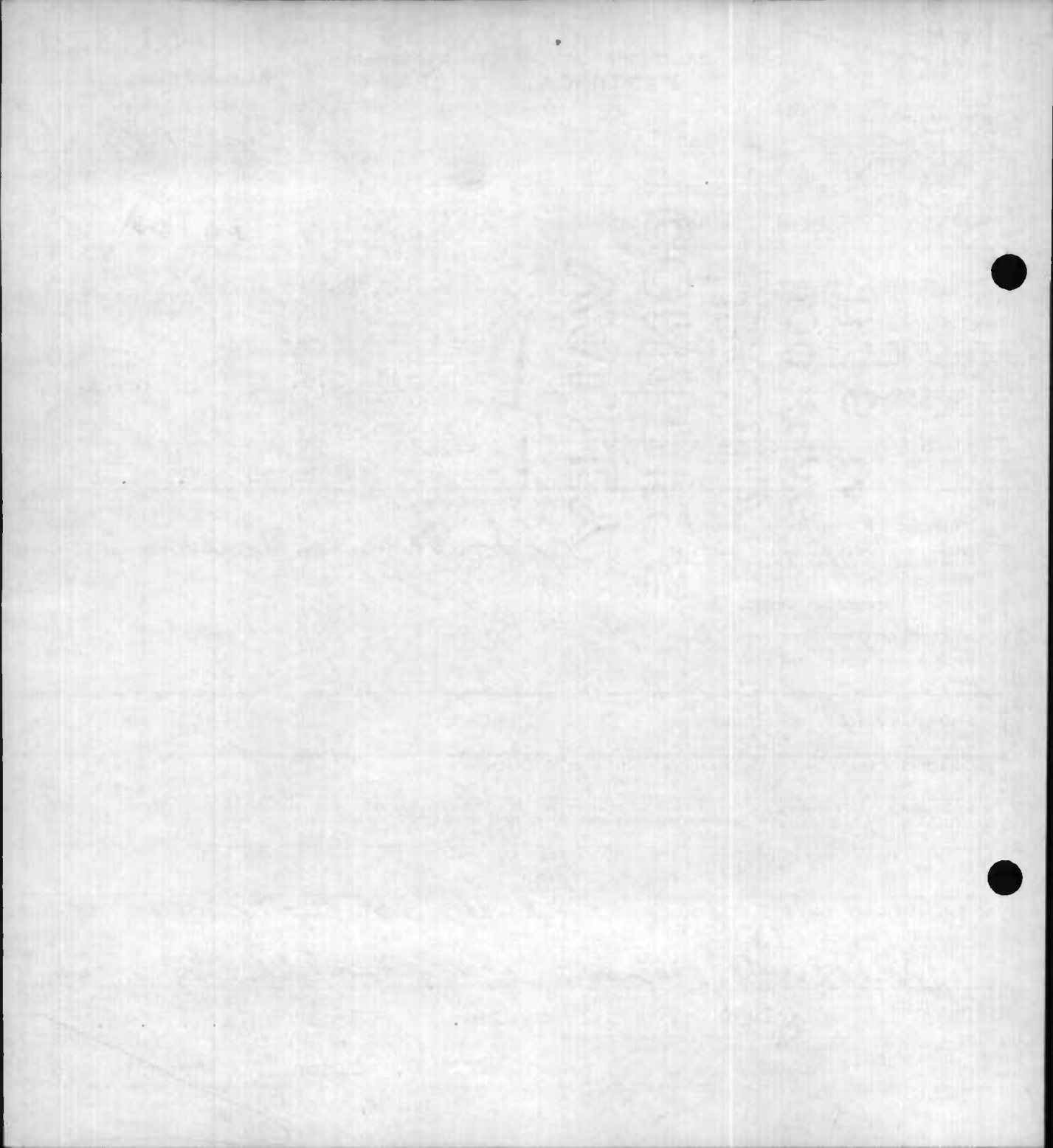
Elroy O. Wilson 1000 Brantly Ave

VS 150

71459

1524-93D

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WALTER H. SHEARER

2. DATE
OF
DEATH

Feb. 20, 1950

1944/10/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

WEST BALTO. GEN. HOSPITAL

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE MARRIED

Married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Administration Officer

10B. KIND OF BUSINESS OR
INDUSTRY

U.S. Govt

13. FATHER'S NAME

Robert C. Shearer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

YES

W.W.I

16. SOCIAL
SECURITY NO.

None

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
before admission)

A. STATE

MD

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Balto

16-06

D. STREET ADDRESS (If rural, give location)

1005 Ashburton St

8. DATE OF BIRTH

Aug 3

9. AGE (In years
last birthday)

57

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Emma Peach

17. INFORMANT

Theresa M. Shearer 1005 Ashburton St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 20, 1950, to Feb. 20, 1950, that I last saw the
deceased alive on Feb. 20, 1950, and that death occurred at 8:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

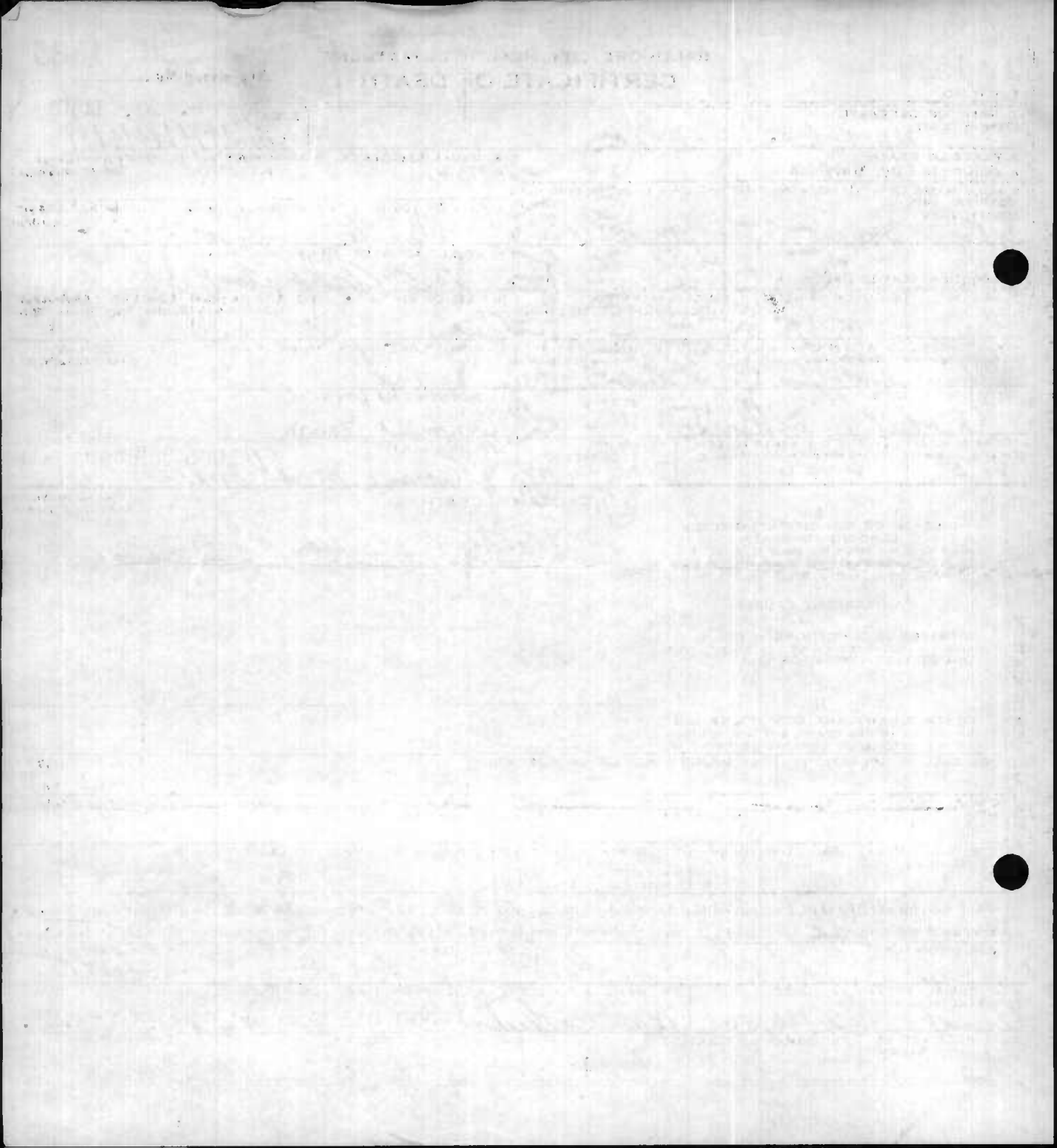
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



532
50 1526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1526
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LANTZ, HOWARD HOWARD W. LANTZ SR.

2. DATE
OF
DEATH

2-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1225 William Street

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

8/10/1887

9. AGE (In years
last birthday)

62

10 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Die Setter

10B. KIND OF BUSINESS OR
INDUSTRY

Nat. En. & Stamp.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Louis L. Lantz

14. MOTHER'S MAIDEN NAME

Laura E. Wheatley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Family - Same

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(A)

DUE TO

Calific Antic Stenosis
Right Pulmonary Edema

(B)

DUE TO

RT. Myocardial
Chronic Pericarditis

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

B

24B. DATE

2/23/50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

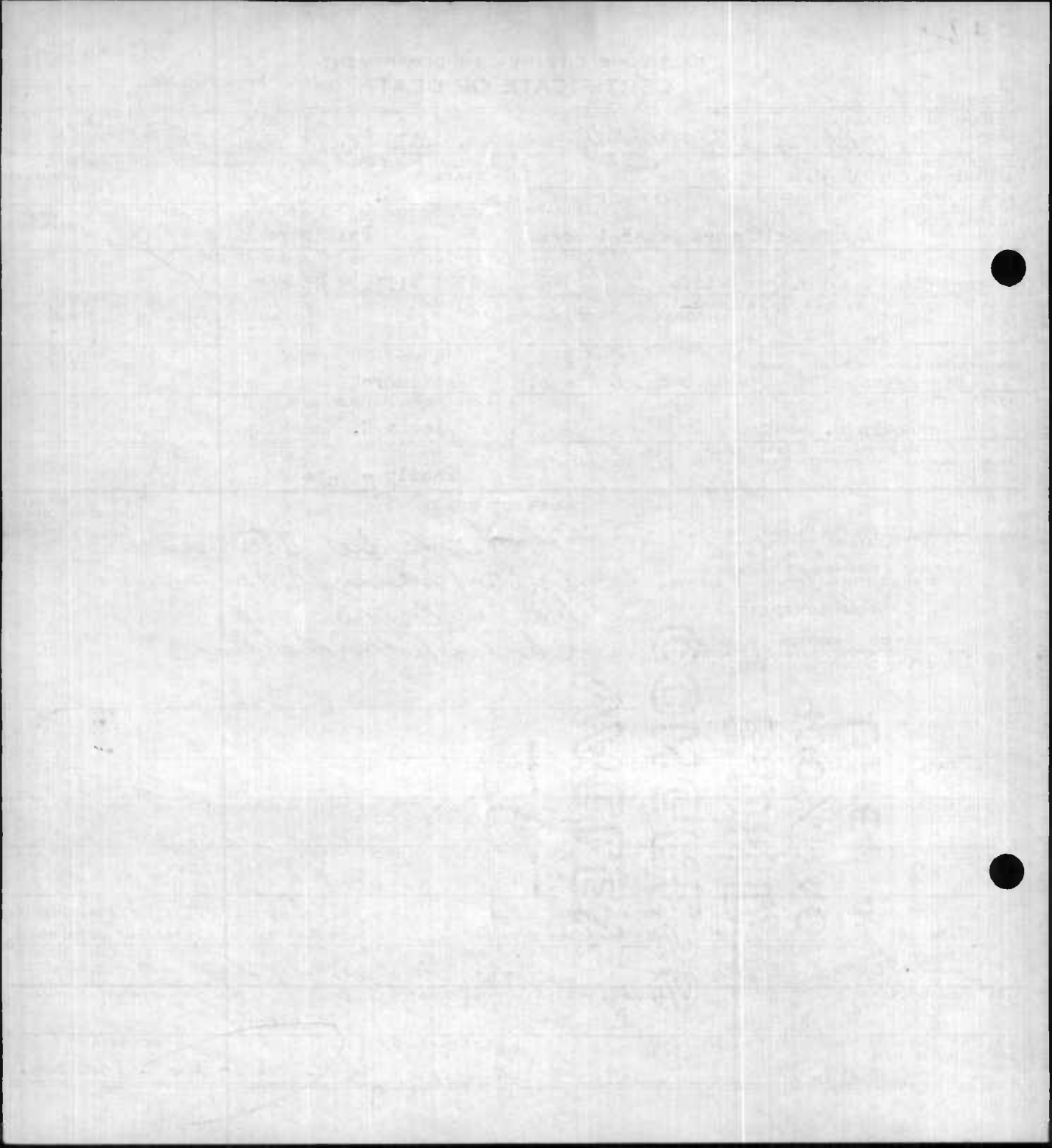
- 130 E. Fort Ave.

FEB 21 1950

VS 150

32830

15282a



220

50 1527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170

50 1527

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY ELIZABETH FEKAYS

2. DATE
OF
DEATH

2/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1718 Patapsco Street

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 23-03D. STREET ADDRESS (If rural, give location)
1718 Patapsco Street

E. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

II/18/1894

9. AGE (In years
last birthday)

55

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR
INDUSTRY

Home

13. FATHER'S NAME

Unknown

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Family - Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Carcinoma Breast (Left).

Generalized Metastases.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☒
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 15 49, to Feb 18, 1950, that I last saw the
deceased alive on Feb 17, 1950 and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

B

24B. DATE

2/22/50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

VS 150

James L. Williams, M.D.

James L. Williams, M.D.

- 130 E. Fort Ave.

50

MEDICAL CERTIFICATION

Dr. Schenck

S. C. Hall, St.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Robert Charles Hodge

2. DATE
OF
DEATH

Feb. 19, 1950

3. PLACE OF DEATH:
A. Baltimore City, Maryland

Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 16-01

B. FULL NAME OF HOSPITAL OR INSTITUTION
Rounden & Sexp.

Length of stay in Baltimore *30 yrs.*
Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)
710 N. Carrollton Ave.

5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Male Col. married

8. DATE OF BIRTH 9. AGE (In years, last birthday) 10. Under 1 Year 11. Under 24 Hours

April 6, 1883 66 6 7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cyster catcher

11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

Saucesville Co., Va. N.C.

13. FATHER'S NAME

James Hodge

14. MOTHER'S MAIDEN NAME

Sausie -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. *722-05-0659*

17. INFORMANT ADDRESS

Maury Hill - 710 N. Carrollton Ave.

18. *584 X I*
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) *Coronary Occlusion*

2/19/50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Initial Hypertension*

2/12/50

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Upper Retroperitoneal Mass, Right Renal Stone, Hypertrophic Arthritis*

over

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2/12*, 1950, to *2/19*, 1950, that I last saw the deceased alive on *2/19*, 1950, and that death occurred at *4:54 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE
Needle

23B. ADDRESS
M. O. *1131 Harlem Avenue*

23C. DATE SIGNED
2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE
2/24/50

24C. NAME OF CEMETERY OR CREMATORY
Sharon Park, Cum.

24D. LOCATION (City, town, or county) (State)
Saucesville Co., Va.

DATE RECEIVED BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR ADDRESS
Geo. P. Nelson, 1303 Punctum St.

Benign mass. Letter in document file 50-1528- 8/7/50.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1529**

BIRTH NO. 1529

1. NAME OF DECEASED
(Type or Print)

Howard Warner

2. DATE OF DEATH Feb. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

309 N. Central Ave.

Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

B. DATE OF BIRTH

10-30-1894

9. AGE (in years last birthday)

56

If Under 1 Year

If Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Coal Truck

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Salman Warner

14. MOTHER'S MAIDEN NAME

Bettie Hawkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Frances Johnson 8007 Spring St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Hemothorax due to rupture of aneurysm of aorta
Luetic aortitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

B. H. Fisher

23B. CHIEF MEDICAL EXAMINER ☐

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER ☒
MEDICAL INVESTIGATOR ☐

Feb. 18, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-22-50

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem

24D. LOCATION (City, town, or county)

A. A. Co

(State)

rmd

DATE RECEIVED BY LOCAL REGISTRAR

FEB 21 1950

REGISTRAR'S SIGNATURE

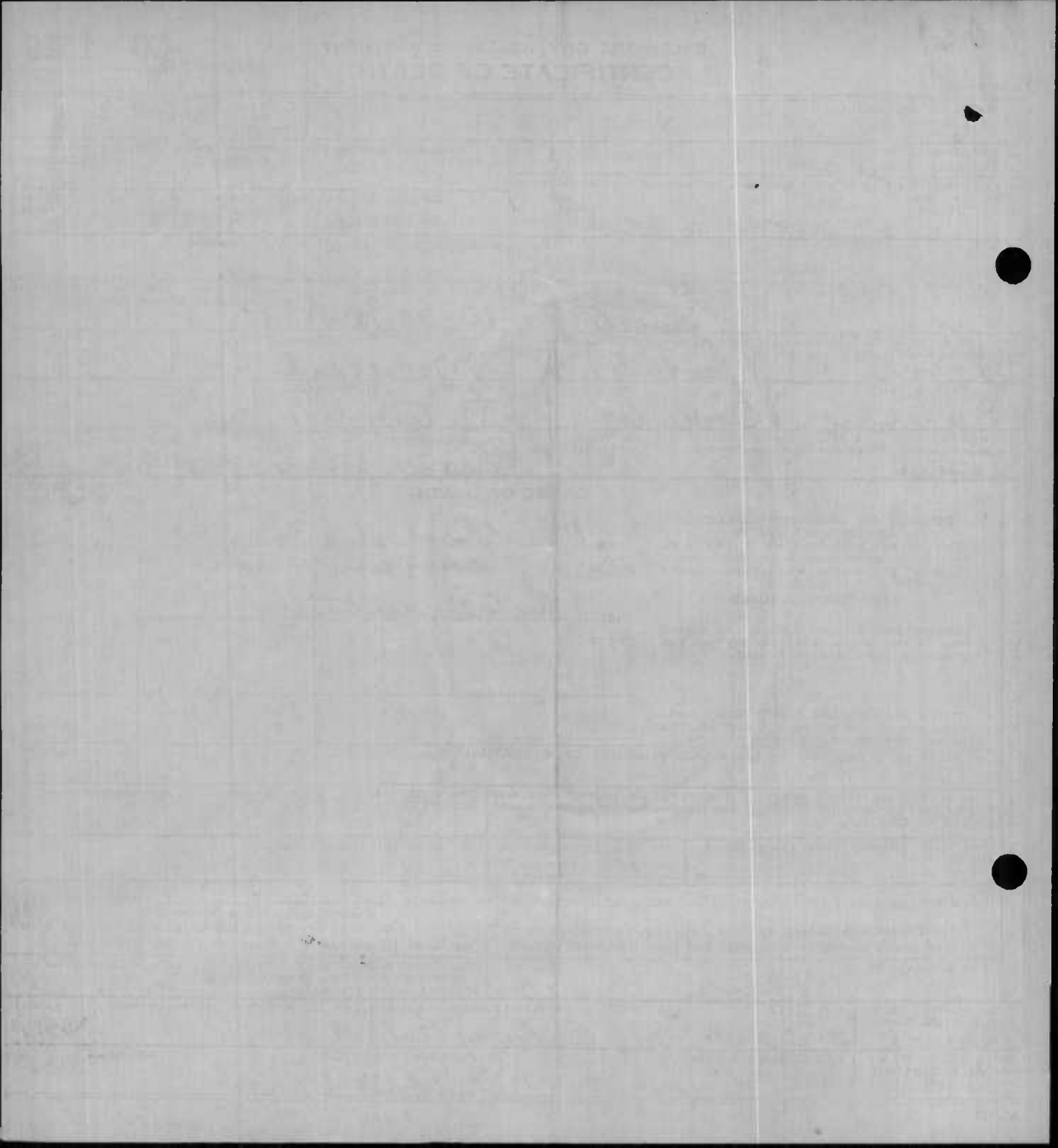
William H. Williams

25. FUNERAL DIRECTOR

R. B. Sanders

ADDRESS

3071 412 E. Preston St



630		CERTIFICATE CORRECTED		5-8-50	
1530		BALTIMORE CITY HEALTH DEPARTMENT		758.1 50 1530	
BIRTH NO. 50-03659		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)		Baby Barrett		2. DATE OF DEATH Feb. 21, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE Md.	
B. FULL NAME OF HOSPITAL OR WYNNDUXDUX		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore 6-01	
Length of stay in Baltimore 5min		D. STREET ADDRESS (If rural, give location)		11 N. Potomac	
5. SEX Female	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb. 21, 1950	9. AGE (In years last birthday)	If Under 1 Year Months: Days Hours: Min. 5
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Newborn		None		Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Frank James Barrett		Jennie Helen Kalbarczyk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		NONE		FRANK J BARRETT 14 N POTOMAC ST.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) Achondrodysplastic Foetus		DUE TO			
19. ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/21/1950 to 2/21/1950, that I last saw the deceased alive on 2/21/1950, and that death occurred at 1:05A.m., from the causes and on the date stated above.					
23A. SIGNATURE Vito L. Coppa		23B. ADDRESS M.D. 1400 N. Caroline St.		23C. DATE SIGNED Feb. 21, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		FEB 21 1950		ST STANISLAUS CEM	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
FEB 21 1950		Huntington Williams, Jr.		DIPPEL BROS 3180 E LOMBARD ST	

1950 157m

STATE OF NEW YORK
CERTIFICATE OF DEATH

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 443

50 1531

BIRTH NO. 50 1531

1. NAME OF DECEASED (Type or Print) CATHERINE BYSENHART		2. DATE OF DEATH Feb. 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 813 N. Madeira St.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
Length of stay in Baltimore life Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 813 N. Madeira St.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb. 2, 1873
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Reus		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Fred Bysenhardt, son - 817 N. Castle St.		ADDRESS	

18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease DUE TO			?
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 4</u> , 19 <u>50</u> , to <u>Feb 18</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>50</u> , and that death occurred at <u>11 P</u> m., from the causes and on the date stated above.			
23A. SIGNATURE Joseph P. Korny M. O.	23B. ADDRESS 2200 E Madison St	23C. DATE SIGNED 2/20/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb. 22, 1950	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Balto. Md.
DATE RECEIVED BY LOCAL REGISTRAR FEB 21 1950	REGISTRAR'S SIGNATURE Thurston H. Williams	25. FUNERAL DIRECTOR Schimmek Funeral Home, Inc. ADDRESS 2601 E. 5th St. Balto. Md.	

CERTIFICATE OF DEATH

THE STATE OF NEW YORK

County of _____

City of _____

Town of _____

Ward of _____

Block of _____

Lot of _____

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

443 50 1532
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH F. FOLKER (FUKA)		2. DATE OF DEATH Feb. 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 3329 E. Monument St.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 00		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-10	
Length of stay in Baltimore life Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3329 E. Monument St.	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jan. 17, 1870
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY Hopper McGaw	9. AGE (In years last birthday) 80
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Fuka		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Sophia E. Folker, 3329 E. Monument St.		ADDRESS	

<p>18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p align="center">CAUSE OF DEATH</p> <p>(A) Cerebral Hemorrhage</p> <p align="center">DUE TO</p> <p align="center">ANTECEDENT CAUSES</p> <p>(B) Hypertensive Cardiovascular disease</p> <p align="center">DUE TO</p> <p>(C) Essential Arterio Sclerosis</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>Jan 15 50</p> <p>Jan 1 48</p> <p>Jan 1940</p>
---	---

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct 1, 1949** to **Jan 19, 1950**, that I last saw the deceased alive on **Jan 19, 1950**, and that death occurred at **2:15 p.m.** from the causes and on the date stated above.

22A. SIGNATURE William J. Ryan, M.D.	23B. ADDRESS 801 E. Kenwood A.	23C. DATE SIGNED 2/20/50
--	--	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/23/50	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Balto. Md.
--	-----------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR Feb 21 1950	REGISTRAR'S SIGNATURE William J. Ryan	25. FUNERAL DIRECTOR Schimmek Funeral Home, Inc.	ADDRESS 2601-3-5 E. Madison St.
--	---	--	---

937

CERTIFICATE OF DEATH

DATE OF DEATH

1923



CERTIFICATE OF DEATH 2-24-50 **BALTIMORE CITY HEALTH DEPARTMENT** 150 50 1533
50 1533
BIRTH NO. 150
BALTIMORE CITY HEALTH DEPARTMENT 150 50 1533
CERTIFICATE OF DEATH Registered No. 150

1. NAME OF DECEASED (Type or Print) **Vincent Barraco** 2. DATE OF DEATH **2-19-1950**

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Balto** B. COUNTY **md**

5. FULL NAME OF HOSPITAL OR INSTITUTION **Mercy Hosp.** 6. CITY OR TOWN **26-01**

7. STREET ADDRESS (If rural, give location) **4325 Hamilton Ave.**

8. DATE OF BIRTH **1888** 9. AGE (In years last birthday) **(63) 61** 10. UNDER 1 Year Months: Days 11. UNDER 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Cooper** 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country) **Italy** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Vincent Barraco** 14. MOTHER'S MAIDEN NAME **Ann ??**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 16. SOCIAL SECURITY NO. **216-03-8912** 17. INFORMANT **Nancy Barraco** ADDRESS **4325 Hamilton Ave.**

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) **carcinoma esophagus** DUE TO

(B) **arterio sclerotic CVD** DUE TO

(C) **old tuberculosis**

(C) **malnutrition**

19A. DATE OF OPERATION **Feb 2, 1950** 19B. MAJOR FINDINGS OF OPERATION **carcinoma of esophagus** 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK 21F. HOW DID INJURY OCCUR?

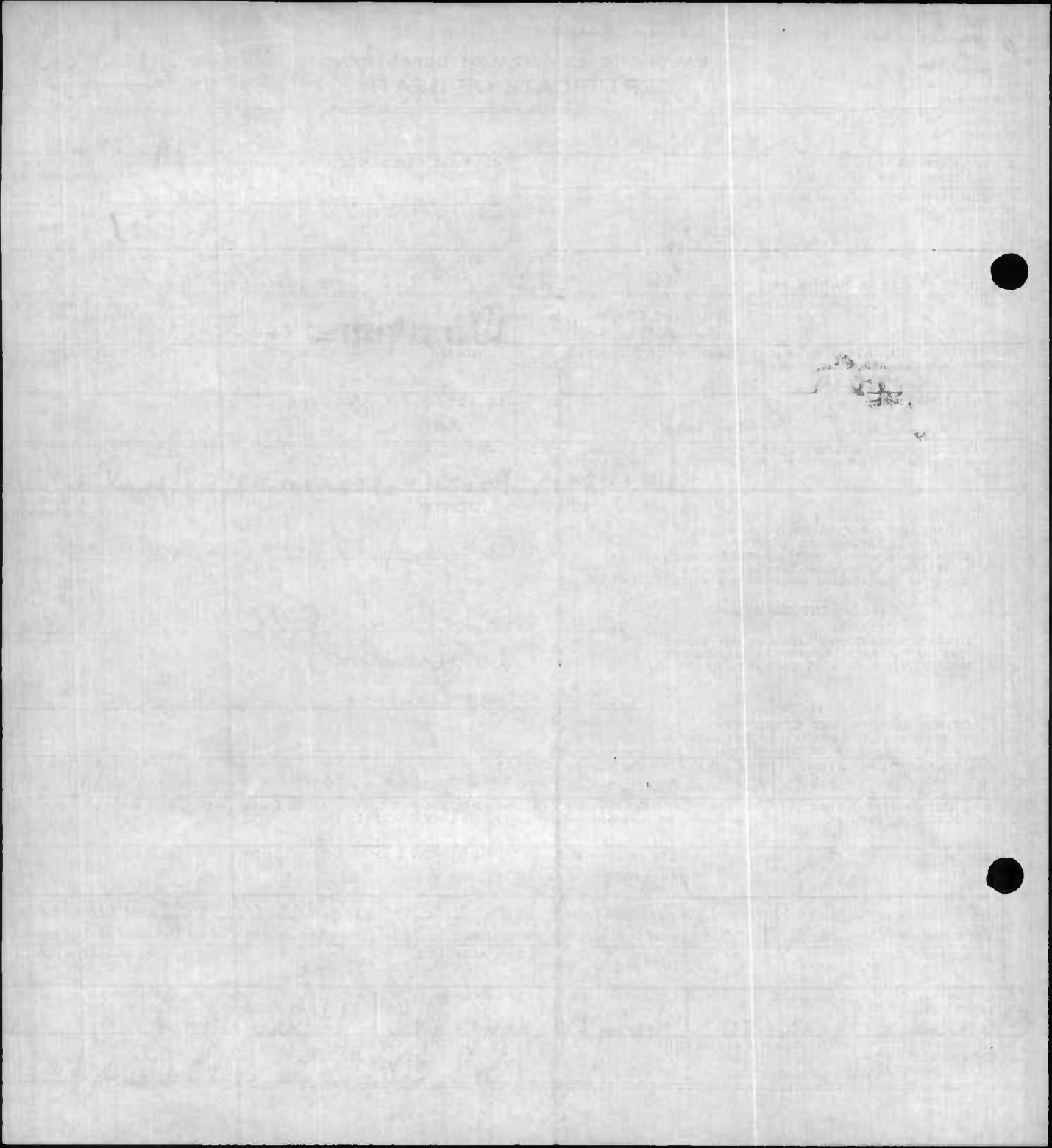
22. I hereby certify that I attended the deceased from **Jan 23, 1950**, to **Feb 19, 1950**, that I last saw the deceased alive on **Feb 19, 1950**, and that death occurred at **8:15 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE **Burton U. Lock M.D.** 23B. ADDRESS **Mercy Hosp.** 23C. DATE SIGNED **2-19-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **2-23-50** 24C. NAME OF CEMETERY OR CREMATORY **Holy Redeemer Cem** 24D. LOCATION (City, town or county) (State) **Belin Ford**

DATE RECEIVED BY LOCAL REGISTRAR **FEB 21 1950** REGISTRAR'S SIGNATURE **John C. Miller** 25. FUNERAL DIRECTOR **John C. Miller** ADDRESS **2455 E. Oliver St**

VS 150 **45610** **46a**



165
50 1534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1534

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harriett E. Levering		2. DATE OF DEATH Feb. 20, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Cecil Apts., Eutaw Place		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY none	
B. FULL NAME OF HOSPITAL OR INSTITUTION 000		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-04	
Length of stay in Baltimore about 35 years Yrs. 35 Mos. 0 Days 0		D. STREET ADDRESS (If rural, give location) Cecil Apts., 1113 Eutaw St.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Feb. 14, 1870
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 80
13. FATHER'S NAME Rev. Frank M. Ellis		11. BIRTHPLACE (State or foreign country) unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY? U.S.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME unknown	
17. INFORMANT Mr. G. Harry Barnes		ADDRESS Homewood Apts.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arterio-sclerosis DUE TO myocardial hypertension		Gradual
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. hypertension		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Oct 7, 1930 to Feb 20, 1950 that I last saw the deceased alive on Feb 20, 1950 , and that death occurred at 7 p.m. , from the causes and on the date stated above.		
23A. SIGNATURE H. H. Hooley	23B. ADDRESS 1403 Park Ave., Balto., Md.	23C. DATE SIGNED 2 - 21 - 50
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 2 - 23 - 50	24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. LOCATION (City, town, or county) Baltimore, Md.		

DATE RECEIVED BY LOCAL REGISTRAR FEB 21 1950	REGISTRAR'S SIGNATURE John O. Mitchell	25. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc.	ADDRESS 1900 Eutaw Pl.
--	--	--	----------------------------------

entire age is especially important. Physicians: Please write the causes of death clearly and legibly.

STATE OF CALIFORNIA

IN SENATE

January 10, 1911

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

FOR THE YEAR

ENDING DECEMBER 31, 1910

AND THE

REVENUE

FROM

THE LAND OFFICE

AND THE

LAND OFFICE

AND THE

LAND OFFICE

AND THE

LAND OFFICE

AND THE

LAND OFFICE

AND THE

LAND OFFICE

AND THE

LAND OFFICE

AND THE

LAND OFFICE

10-11-50

10-11-50

50 1535

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1535

1. NAME OF DECEASED
(Type or Print)

Daniel Standish Clark

2. DATE
OF
DEATH

FEB 21 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

d. STREET ADDRESS (If rural, give location)

80 Wales Ave

Length of stay in Baltimore

0

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Infant

8. DATE OF BIRTH

8-22-49

9. AGE (In years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

6 5 29

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, oo or oookooos) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Congenital Heart Disease
cyanotic

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Operation for relief of above.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

M.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-16-1949 to 2-21-1950, that I last saw the
deceased alive on 2-21-1950, and that death occurred at 3:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Lemuel F. Rosenzweig

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

21 Feb 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

2-21-50

24C. NAME OF CEMETERY OR CREMATORY

River Edge City

24D. LOCATION (City, town, or county)

New Jersey

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

VS 150

Wm. Cook Inc. 7 1217 St. Paul St.

157E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF NEW YORK
CERTIFICATE OF DEATH

1. Name of Deceased: *John J. White*
2. Date of Death: *Dec 15 1912*
3. Place of Death: *Home*
4. Age: *65*
5. Sex: *Male*
6. Cause of Death: *Heart Disease*
7. Signature of Physician: *John J. White*

8. Signature of Registrar: *John J. White*
9. Date of Registration: *Dec 15 1912*
10. Place of Registration: *Home*

11. Signature of Deceased: *John J. White*
12. Date of Signature: *Dec 15 1912*
13. Place of Signature: *Home*

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1536
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES EDWARD DENNIS

2. DATE
OF
DEATH

Feb. 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2075 Rock Rose Ave.

Yrs.
Mos.
Days

Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Sept. 20, 1875

9. AGE (In years
last birthday)

74

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

clerk

10B. KIND OF BUSINESS OR
INDUSTRY

paper

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Geo. W. Dennis

14. MOTHER'S MAIDEN NAME

Susie Goodman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Edythe G. Turner - 5532 Link Ave.

ADDRESS
Arbutus, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

liberal hemorrhage
and paralysisabout
2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arterio-sclerosis

?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

DUE TO

myocarditis

4 mo.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from June 1948, 19, to Feb. 19, 1950, that I last saw the deceased alive on Feb. 19, 1950, and that death occurred at 6 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

2220 Garrison Blvd

Feb 20/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

2/22/50

Druid Ridge Cem.

Pikesville, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

J. TICKNER & SONS

Balto., Md.

VS 150

266780

1538

93D

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

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WASHINGTON, D. C.

OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 1537

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

ANNIE BRADUNIS

2. DATE
OF

DEATH Feb 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

22-01

O. STREET ADDRESS (If rural, give location)

129 W. Camden St.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

129 W. Camden St.

Yrs.

Mos.

Days

Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

Dec..14, 1878

9. AGE (In years last birthday)

71

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

seamstress

10B. KIND OF BUSINESS OR INDUSTRY

clothing Mfg.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Sylvester Stieger

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Peter Bradunis 129 W. Camden St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Senile Chorea

2 years

DOE TO

myo car later

(B)

arterio sclerosis

DOE TO

(C)

chronic arthritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2/10/1950 to 2/19/1950, that I last saw the deceased alive on 2/19/1950, and that death occurred at 5:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Dr. J. J. Brander

M. O.

1424 Lee

2/20/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/22/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 21 1950

Wm. J. Tickner & Sons

WM. J. TICKNER & SONS

Balto., Md.

VS 150

496448

93D

12/14/78

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1538
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNA LOUISE McBRIDE

2. DATE OF DEATH
Feb. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2637 N. Charles St.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 12-06D. STREET ADDRESS (If rural, give location)
2637 N. Charles St.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

B. DATE OF BIRTH

Mar. 27, 1880

9. AGE (In years last birthday)
69

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

I. Newton Wood

14. MOTHER'S MAIDEN NAME

Anna Mary Griffith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no16. SOCIAL SECURITY NO.
no17. INFORMANT ADDRESS
Mr. C. A. McBride 2637 N. Charles St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

1 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Sclerosis + generalized arteriosclerosis

DUE TO

? years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to Feb 20, 1950, that I last saw the deceased alive on Feb 20, 1950, and that death occurred at 8:32 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Francis W. Gluck

M. D.

23B. ADDRESS

3406 St Paul St

23C. DATE SIGNED

2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

2/22/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Maus.

24D. LOCATION (City, town, or county) (State)

Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNERY & SONS

Balto., Md.

CERTIFICATE OF DEATH

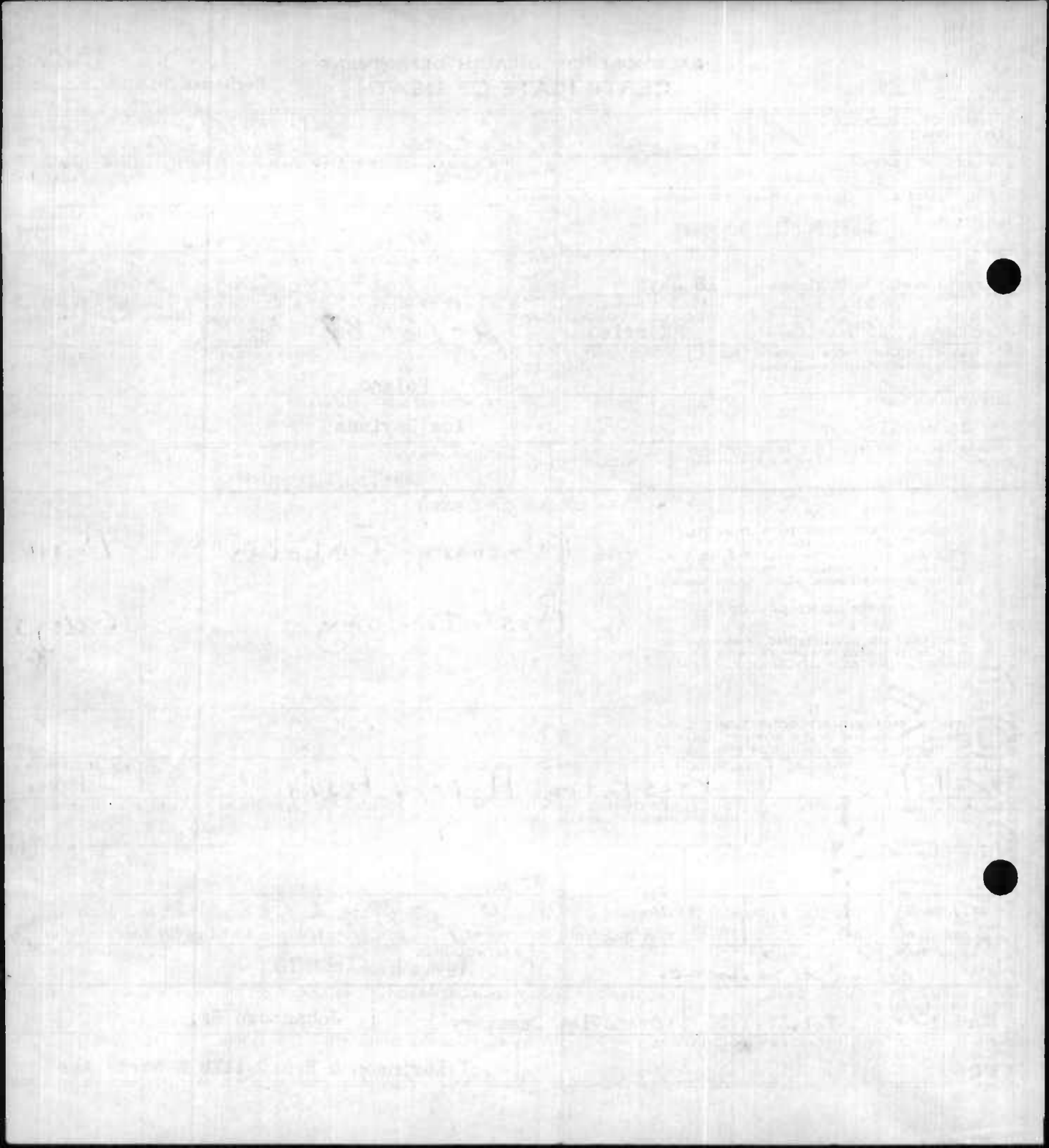
1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Informant		12. Signature of Coroner	
13. Signature of Medical Examiner		14. Signature of Police Officer		15. Signature of Funeral Home	
16. Signature of Burial Place		17. Signature of Cemetery		18. Signature of Interment	
19. Signature of Burial		20. Signature of Burial		21. Signature of Burial	
22. Signature of Burial		23. Signature of Burial		24. Signature of Burial	
25. Signature of Burial		26. Signature of Burial		27. Signature of Burial	
28. Signature of Burial		29. Signature of Burial		30. Signature of Burial	
31. Signature of Burial		32. Signature of Burial		33. Signature of Burial	
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46. Signature of Burial		47. Signature of Burial		48. Signature of Burial	
49. Signature of Burial		50. Signature of Burial		51. Signature of Burial	
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64. Signature of Burial		65. Signature of Burial		66. Signature of Burial	
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70. Signature of Burial		71. Signature of Burial		72. Signature of Burial	
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76. Signature of Burial		77. Signature of Burial		78. Signature of Burial	
79. Signature of Burial		80. Signature of Burial		81. Signature of Burial	
82. Signature of Burial		83. Signature of Burial		84. Signature of Burial	
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88. Signature of Burial		89. Signature of Burial		90. Signature of Burial	
91. Signature of Burial		92. Signature of Burial		93. Signature of Burial	
94. Signature of Burial		95. Signature of Burial		96. Signature of Burial	
97. Signature of Burial		98. Signature of Burial		99. Signature of Burial	
100. Signature of Burial		101. Signature of Burial		102. Signature of Burial	

426
50 1539
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1539
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Solomon G. Glosser</i>		2. DATE OF DEATH <i>Feb. 21, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Pa</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Johnstown</i>	
Length of stay in Baltimore <i>15 Days</i>		D. STREET ADDRESS (If rural, give location) <i>405 Helen St</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>12-16-87</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>62</i>
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Moses Glosser</i>		14. MOTHER'S MAIDEN NAME <i>Ida Davimes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

MEDICAL CERTIFICATION	18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary Embolus</i>	INTERVAL BETWEEN ONSET AND DEATH <i>45 MIN</i>
	II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Prostatectomy</i>	<i>10 days</i>
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <i>2/8/50</i>		19B. MAJOR FINDINGS OF OPERATION <i>Prostatic Hyperplasia</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2/6</i> , 19 <i>50</i> , to <i>2/21</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>2/21</i> , 19 <i>50</i> , and that death occurred at <i>1:15 Pm.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Paul H. Burre</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Feb. 23, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>GrandView Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Johnstown Pa,</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 22 1950</i>		24F. REGISTRAR'S SIGNATURE <i>W. H. H. H.</i>	
24G. FUNERAL DIRECTOR <i>Sol Levinson & Bros</i>		24H. ADDRESS <i>1126 W North Ave</i>		24I. DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 22 1950</i>	



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

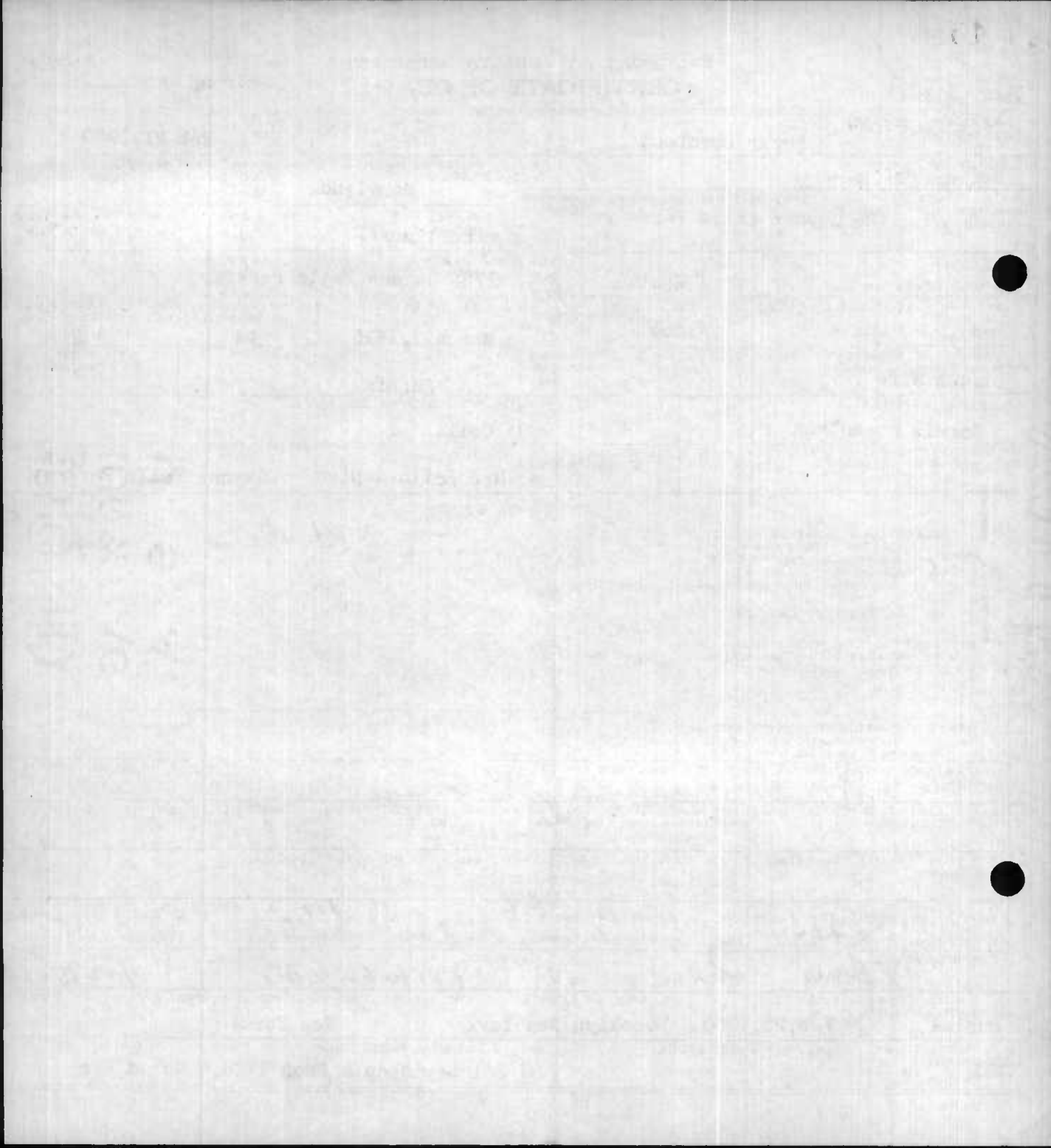
651
50 1540

50 1540

1. NAME OF DECEASED (Type or Print) Becky Bernback			2. DATE OF DEATH Feb 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1725 Gwynns Falls Parkway			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 1725 Gwynns Falls Parkway			13-04		
Length of stay in Baltimore 3 Months			Yrs. _____ Mos. _____ Days _____		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH March 7, 1895	9. AGE (In years last birthday) 54	II Under 1 Year Months: _____ Days: _____ II Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Morris Rosenbaum			14. MOTHER'S MAIDEN NAME Celia ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS 1725 Gwynns Falls Parkway Mrs Edith Kaplan		

MEDICAL CERTIFICATION	18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
	I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Rt Breast (A) _____ DUE TO		
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) _____			

19A. DATE OF OPERATION Dec. 6, 1949		19B. MAJOR FINDINGS OF OPERATION Carcinoma of Rt Breast		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 1 , 19 50 , to Feb 21 , 19 50 , that I last saw the deceased alive on Feb 21 , 19 50 , and that death occurred at 8.30 pm. , from the causes and on the date stated above.					
23A. SIGNATURE Dr. Harry Ashman		23B. ADDRESS 1921 W North Ave		23C. DATE SIGNED 2/22/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb. 23, 1950		24C. NAME OF CEMETERY OR CREMATORY Brooklyn New York	
24D. LOCATION (City, town, or county) (State) New York		25. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros 1126 W North Ave			



235

50 1541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

REV. ROBERT Mc CUTCHEN

2. DATE
OF
DEATH

2/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

PENNA.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Church Home & Hospital

C. CITY OR TOWN

SOUTH Mountn.

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

None

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Nov. 4, 1881

9. AGE (In years
last birthday)

68

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Minister

10B. KIND OF BUSINESS OR
INDUSTRY

Episcopalian

11. BIRTHPLACE (State or foreign country)

Wisconsin

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John C. McCutchen

14. MOTHER'S MAIDEN NAME

Ada M. Hull

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, No or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Marshall Augustine Cunningham

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Myocardial infarction

4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B)

Left Atherosclerosis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 2/18, 1950, to 2/21, 1950, that I last saw the
deceased alive on 2/21, 1950, and that death occurred at 7:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Robert E. Enos

23B. ADDRESS

Church Home & Hosp. 2/21/50

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

2/24/50

24C. NAME OF CEMETERY OR CREMATORY

Strange

24D. LOCATION (City, town or county) (State)

Pa.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 22 1950

Walter J. Enos

275 Church & Wagoner Pa.

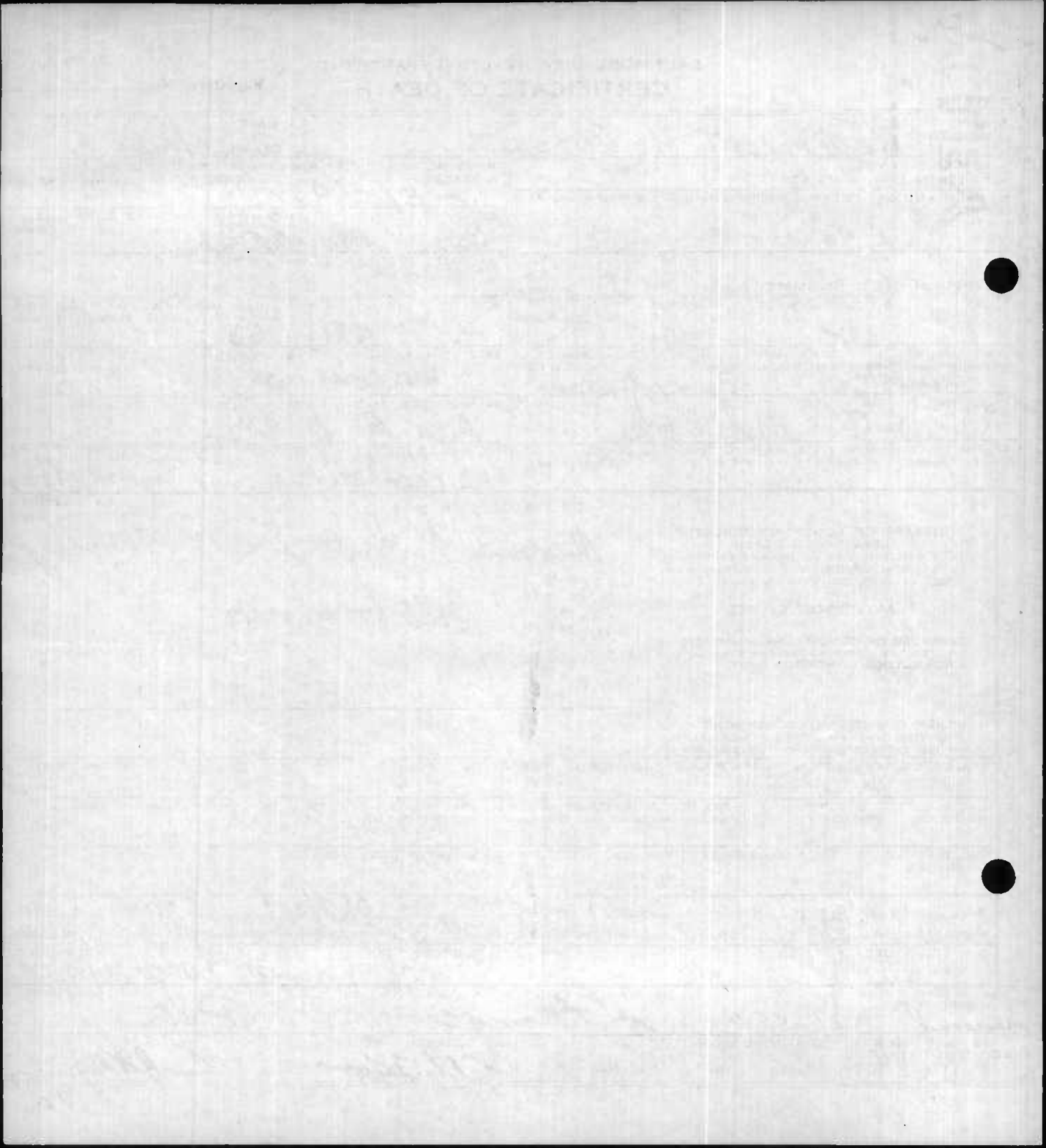
VS 150

V0894

94a

correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1542**

BIRTH NO. **50 1542**

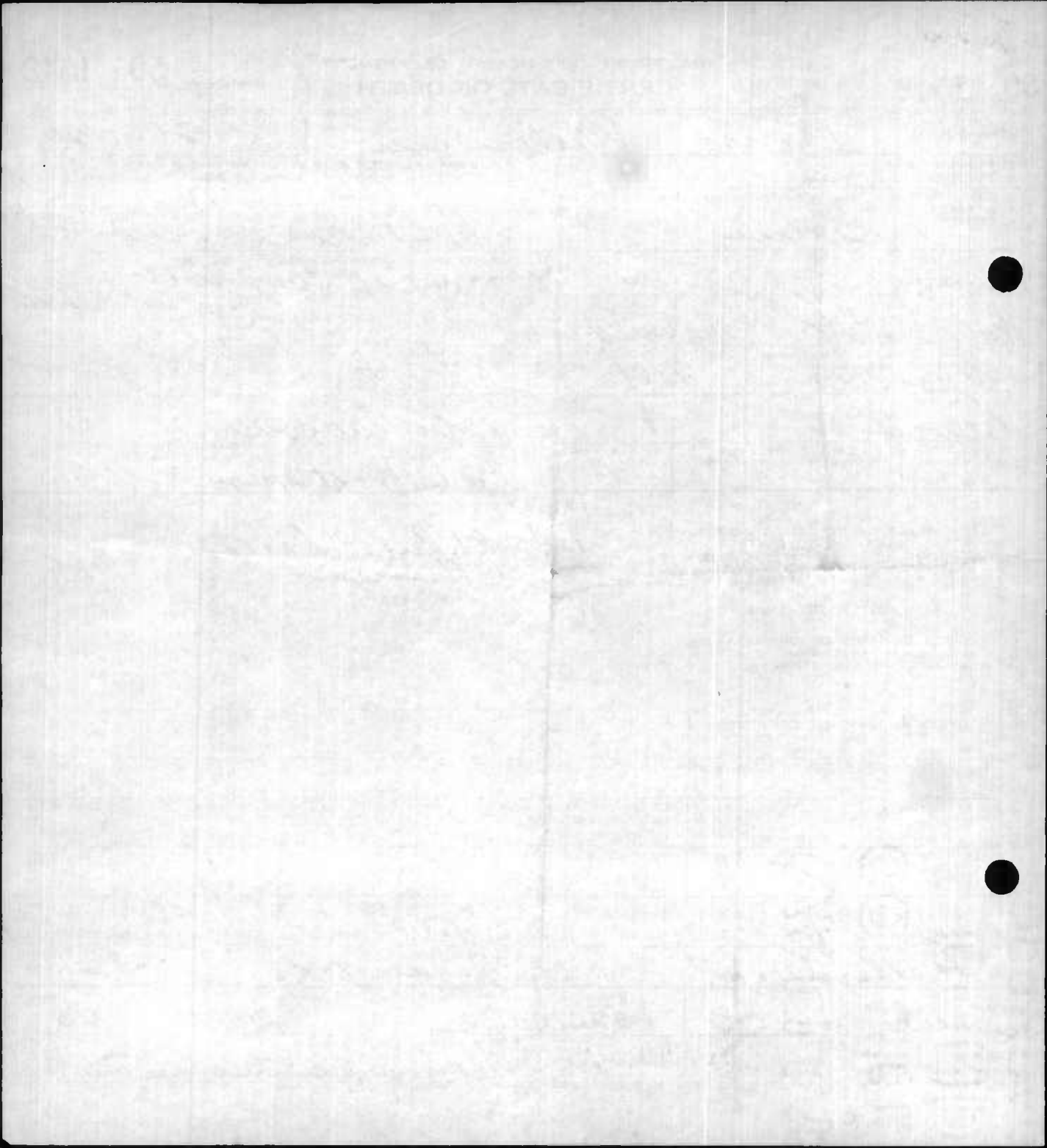
1. NAME OF DECEASED (Type or Print) MICHAEL Westerman		2. DATE OF DEATH 2/21/50	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Md b. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION Senar		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-03	
5. LENGTH OF STAY IN BALTIMORE 40 Yrs. 40 Mos. 40 Days		d. STREET ADDRESS (If rural, give location) 2219 East Fairmount Ave	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 7-2
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Grocer		10b. KIND OF BUSINESS OR INDUSTRY self	
13. FATHER'S NAME Daved		11. BIRTHPLACE (State or foreign country) Lith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? Not Known	
16. SOCIAL SECURITY NO.		17. INFORMANT Freda Westerman	
		ADDRESS	

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) HAS Chronic Disease c Anemia DUE TO			INTERVAL BETWEEN ONSET AND DEATH
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO			
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-17 , 19 50 , to 2-21 , 19 50 , that I last saw the deceased alive on 2/21 , 19 50 , and that death occurred at 2:30 P m., from the causes and on the date stated above.			
23A. SIGNATURE Leonard Kotz	23B. ADDRESS Senar Hosp	23C. DATE SIGNED 2/21/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2-22-50	24C. NAME OF CEMETERY OR CREMATORY Rosedale	24D. LOCATION (City, town, or county) (State) Balto Md
DATE RECEIVED BY LOCAL REGISTRAR FEB 22 1950	REGISTRAR'S SIGNATURE Thurston Williams	25. FUNERAL DIRECTOR Jack Hennighe	
		ADDRESS 2100 Canton Rd	

MEDICAL CERTIFICATION

15661

1310



253

BIRTH NO. 1543 JL-103841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1543
Registered No.

1. NAME OF DECEASED (Type or Print) John McEntee		2. DATE OF DEATH 2-20-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ma. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-07	
Length of stay in Baltimore 70 yrs. ? Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) No Street Address B. C. H. Inf.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH June ? 1878 (1881)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press operator		10B. KIND OF BUSINESS OR INDUSTRY Can Company	9. AGE (In years last birthday) Months Days 71 ? (69) 8 5
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dan McEntee		14. MOTHER'S MAIDEN NAME Mary Grant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. ?	17. INFORMANT ADDRESS B. C. H. Records, 4940 Eastern Ave	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Pulmonary Edema DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Post operative Shock DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) Carcinoma of the Esophagus		

19A. DATE OF OPERATION 2-20-50		19B. MAJOR FINDINGS OF OPERATION Esophagectomy		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-17-46 , 19__, to Feb. 20 , 19 50 , that I last saw the deceased alive on Feb. 20 , 19 50 , and that death occurred at 7.05 PM , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i> M. D.		23B. ADDRESS 4940 Eastern Ave.		23C. DATE SIGNED 2-20-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-23-50		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Edmondson Ave. Balto: Md.		25. FUNERAL DIRECTOR ADDRESS George J. Ruth, Inc. - 1735 Harford Avenue			

4963V

46a

J. A.

1910-1911

1911-1912

1912-1913

1913-1914

1914-1915

1915-1916

1916-1917

1917-1918

1918-1919

1919-1920

1920-1921

1921-1922

1922-1923

1923-1924

1924-1925

1925-1926

1926-1927

1927-1928

1928-1929

1929-1930

1930-1931

300
50 1544
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1544
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Mary White</i>		2. DATE OF DEATH <i>Feb. 18, 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 7-05</i>	
Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>621 N. Wallas St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 66</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife at home</i>		11. BIRTHPLACE (State or foreign country) <i>Betha M</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Thomas Cherry</i>		14. MOTHER'S MAIDEN NAME <i>Sarah</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i> ADDRESS	

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Emorrhage from left middle cerebral artery</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 h.</i>
DUE TO (A)		
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertension</i>		DUE TO (B) <i>yes</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DUE TO (C)
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Feb. 17, 1940</i> to <i>Feb. 18, 1940</i> that I last saw the deceased alive on <i>Feb. 18, 1940</i> , and that death occurred at <i>9:30 a.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>David L. Brown</i> M.D.		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>
23C. DATE SIGNED <i>2-18-50</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Feb. 22-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Int Calvary Cemetery</i>
24D. LOCATION (City, town, or county) <i>A.A. Co, Md</i>		(State)
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 22 1950</i>		REGISTRAR'S SIGNATURE <i>William M. ...</i>
25. FUNERAL DIRECTOR <i>Robert M. ...</i>		ADDRESS <i>1575 McElderry</i>

83a

John

IN SENATE,
January 12, 1911.

REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1909.

ALBANY:
J.B. LEECH, PRINTERS,
1911.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

593 50 1545
Registered No. _____

560
BIRTH NO. 1545

1. NAME OF DECEASED (Type or Print) <i>Frederick W. Neumayer</i>		2. DATE OF DEATH <i>2/20/50 2 P.M.</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>3509 Brendan Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. 26-03</i>	
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>3509 Brendan Ave.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>6/26/1874</i>
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Retired Supt.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Arthur Thompson & Co</i>	
13. FATHER'S NAME <i>Frederick W. Neumayer</i>		14. MOTHER'S MAIDEN NAME <i>Priscilla Stender</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Fred. A. Neumayer</i>		ADDRESS <i>3509 Brendan Ave.</i>	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>one bad turn on large 3 hrs</i>		
DUE TO (A) _____		
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>arteriosclerosis</i>		
DUE TO (B) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>hypertension</i>		
DUE TO (C) _____		

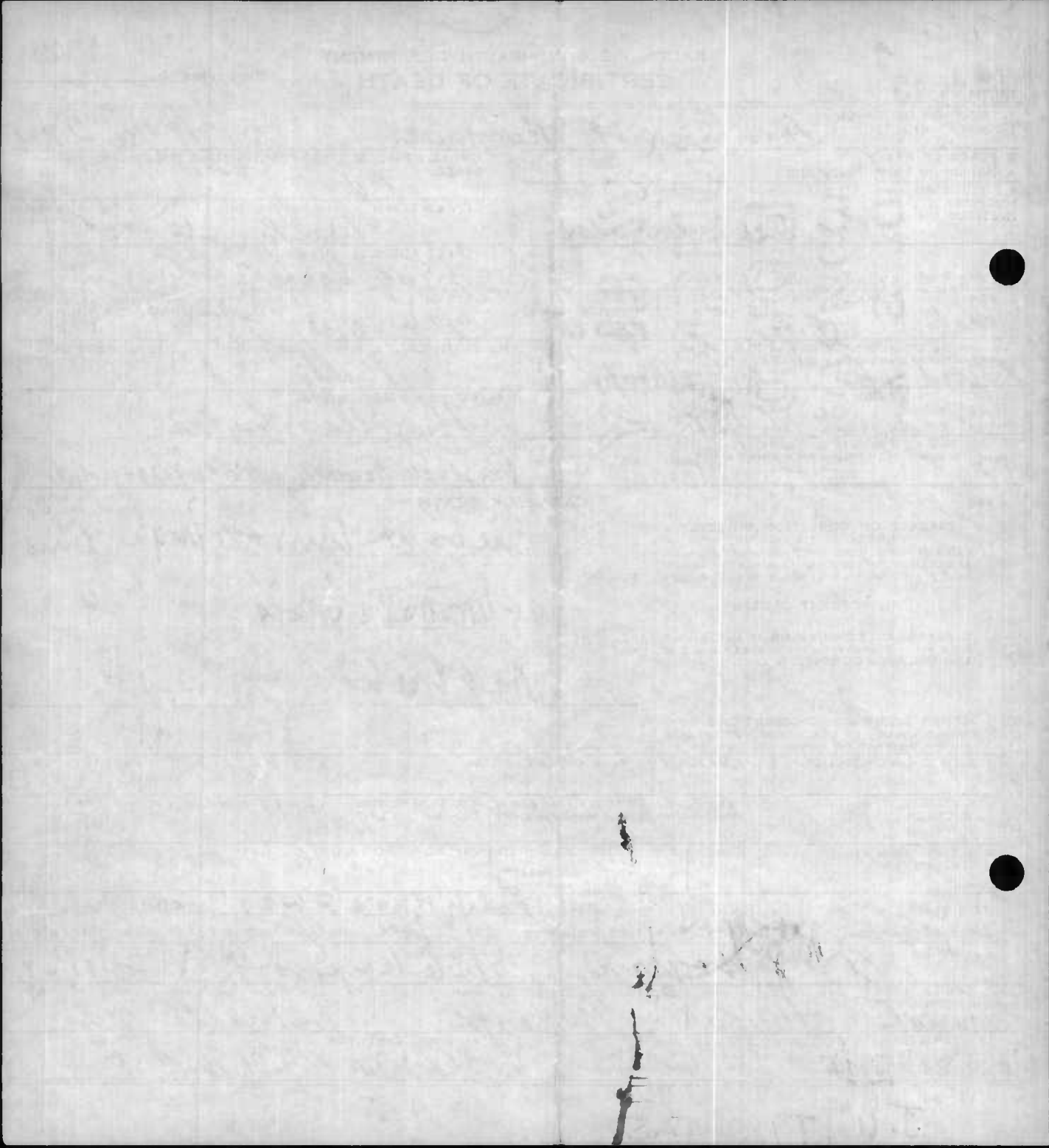
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Jan 14 1940</i> to <i>Feb 20</i> , 19 <i>50</i> that I last saw the deceased alive on <i>Jan 14</i> and that death occurred at <i>home</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>J. W. Thoms</i>		23B. ADDRESS <i>818 Calverton Rd.</i>		23C. DATE SIGNED <i>Feb 21/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2/23/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	24D. LOCATION (City, town, or county) (State) <i>Parkville Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 22 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. C. G. Dine</i>		25. FUNERAL DIRECTOR <i>1217 St. Paul St.</i>

J. W. THOMAS

1517

131a

correct age is especially important. Physicians, please write the cause of death clearly and legibly.



500

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1546

BIRTH NO. 1546

1. NAME OF DECEASED
(Type or Print)

Elinore Perkins Davis Lyon

2. DATE
OF
DEATH

Feb 20 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 4000 Ginnway

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

at home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

30 yrs

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)10. Under 1 Year
Months; Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cerebral hemorrhage

Feb 19 50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Bronchopneumonia

Feb 10 50

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Hypertensive Cardiovascular Ds

10 yrs -

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Feb 10, 1950, to Feb 20, 1950, that I last saw the
deceased alive on Feb 20, 1950 and that death occurred at 3:07 pm, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Benjamin H. H. H.

M. D.

18 Eager St Balto Md

Feb 20 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 22 1950

VS 150

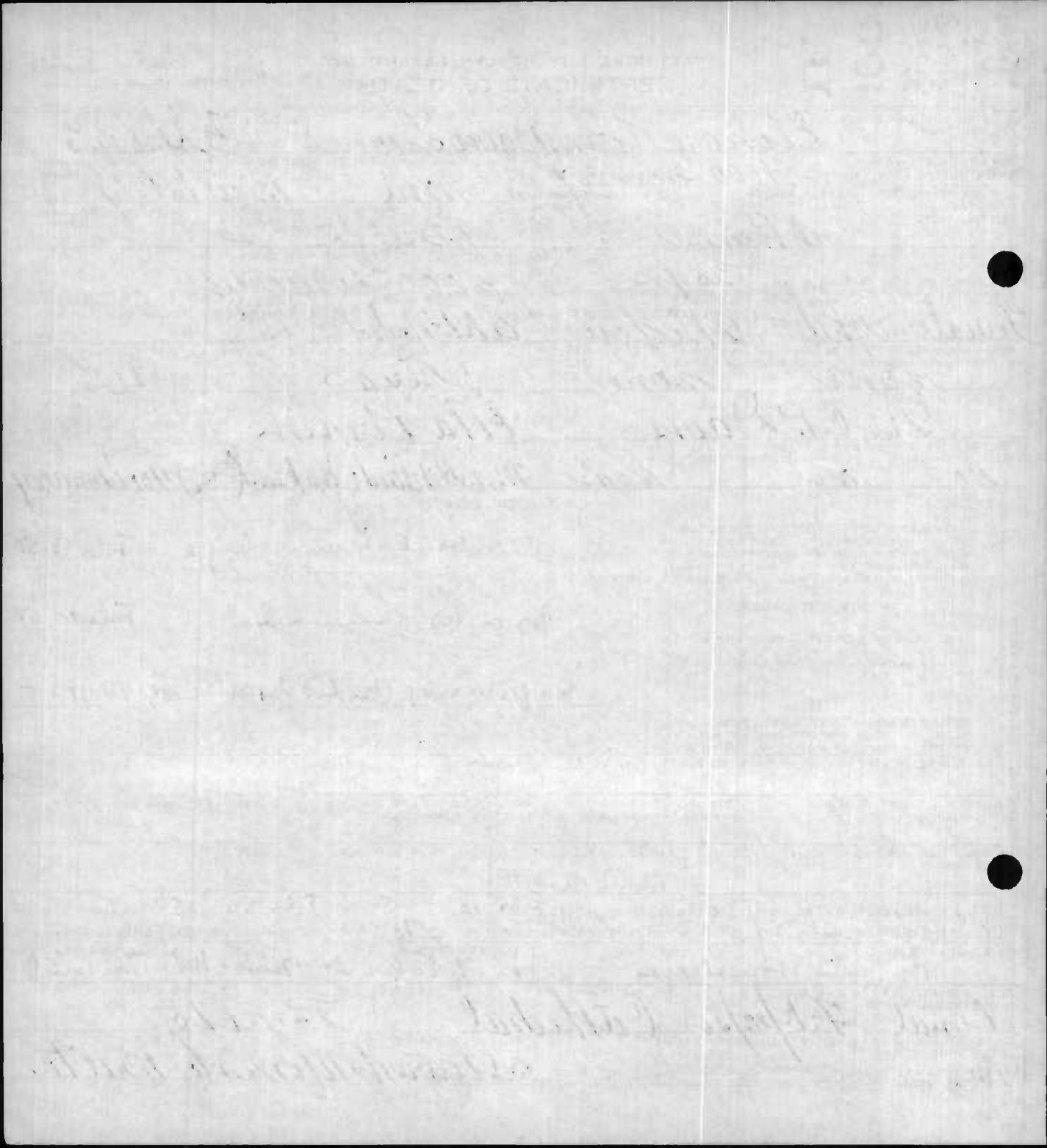
Stewart M. H. H.

Stewart M. H. H. Balto.

1546

93D

correct age is especially important. Physicians, please write the cause of death clearly and legibly.



650
50 1547BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1547

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sister Mary Joseph Moran

2. DATE
OF
DEATH

2-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 6420 Peistenstown Road

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE The Seton Institute

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 28-01D. STREET ADDRESS (If rural, give location)
6420 Peistenstown Rd.

Length of stay in Baltimore

13 Yrs.
10 Mos.
8 Days

5. SEX

F

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

10-31-1866

9. AGE (In years,
last birthday)

83

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Catholic Sister

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thaddeus Moran

14. MOTHER'S MAIDEN NAME

Many (family name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

The Seton Institute - Balto., Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Myocardial infarct 2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arterio sclerosis (General) 46 weeks

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

DUE TO

psychosis (Arterio-sclerosis) 46 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 14, 1948 to Feb. 20, 1950, that I last saw the
deceased alive on Feb. 20, 1950, and that death occurred at 10:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Walter L. Jahnke

M. D.

23B. ADDRESS

The Seton Institute, Balto. 2/20/1950

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

1 State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 22 1950

Thurston William

Stewart & Moore Company, 108 W. North A.

VS 150

V6894

94a

City #1.

50 1548

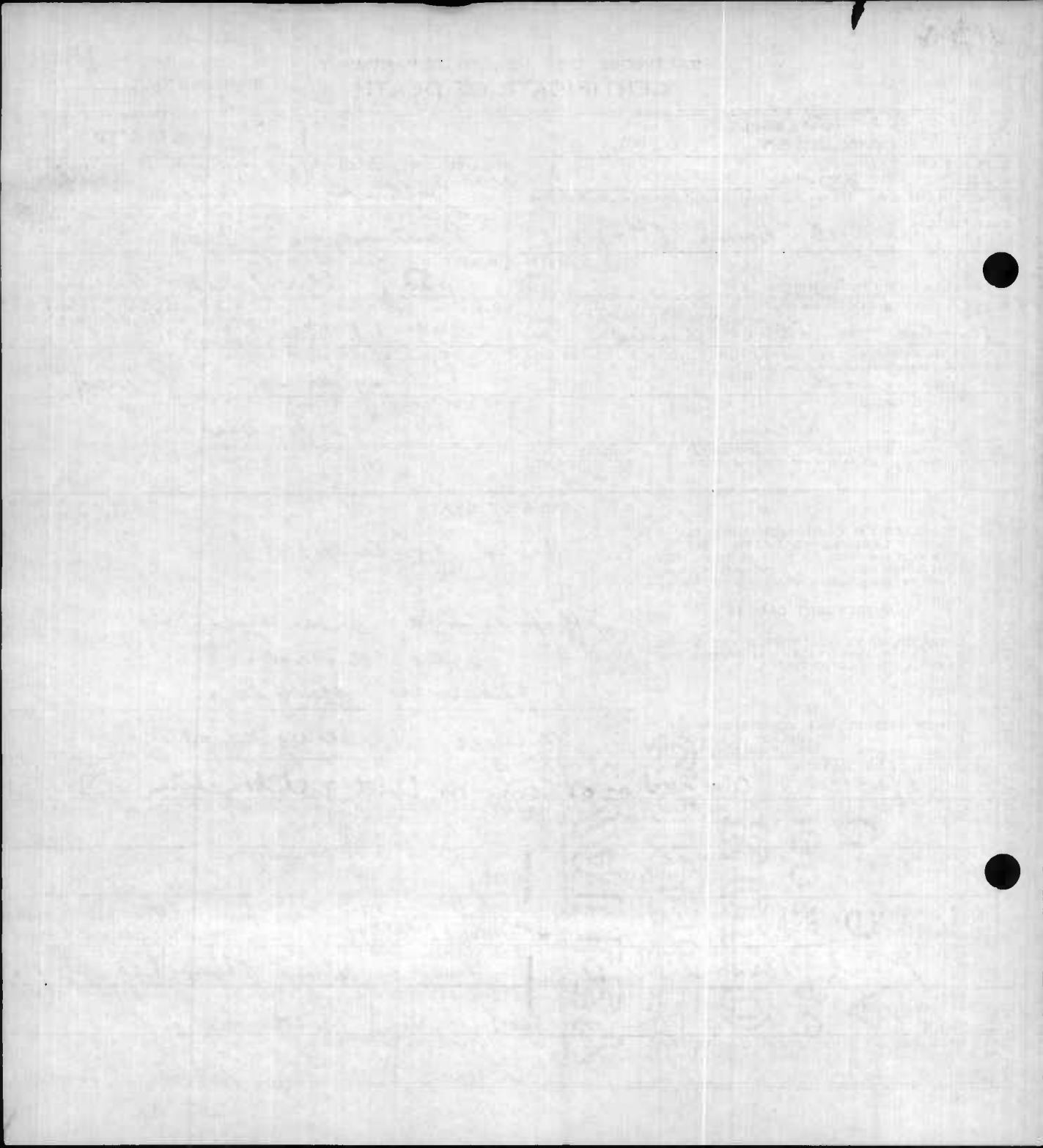
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1548
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GWENDOLYN WILSON		2. DATE OF DEATH 2/20/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY Ind.	
B. FULL NAME OF HOSPITAL OR INSTITUTION Church Home Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-06	
D. STREET ADDRESS (If rural, give location) 6527 Cleveland Avenue		5. LENGTH OF STAY IN BALTIMORE 2 5 1/2 Yrs. Mos. Days	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Oct. 17, 1885
9. AGE (In years last birthday) 62 Yrs.		10. KIND OF BUSINESS OR INDUSTRY Housewife	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? Ind.		13. FATHER'S NAME John Reese	
14. MOTHER'S M maiden NAME Mary Davis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

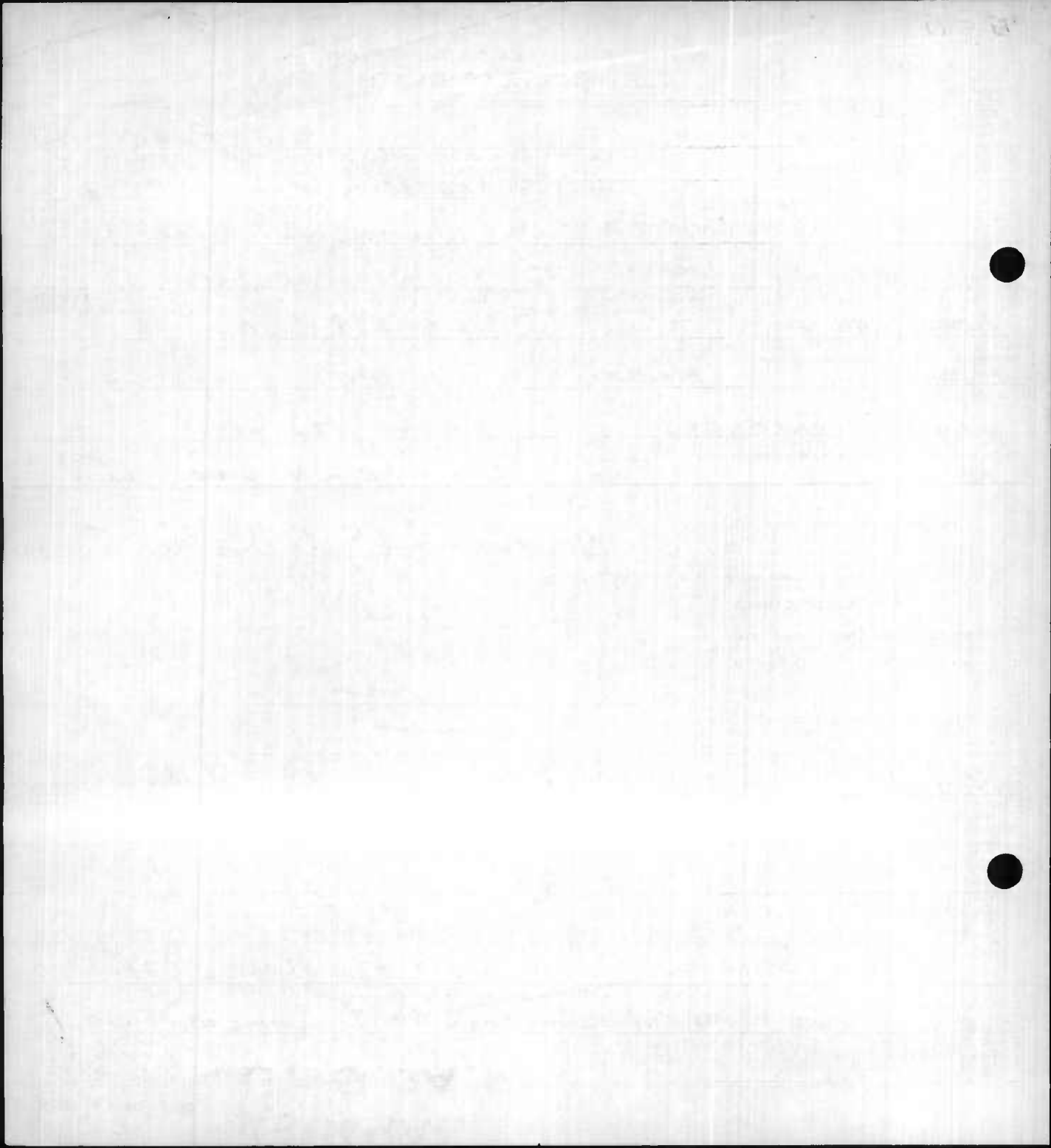
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Heart failure.		
DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Hypertensive arteriosclerosis heart disease.		
DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) Chronic Cholecystitis.		
19A. DATE OF OPERATION 2/18/50		19B. MAJOR FINDINGS OF OPERATION Obstruction of Common Duct = Cholecystitis
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 2/6/50 , 19 50 to 2/20/50 , 19 50 that I last saw the deceased alive on 2-20 , 19 50 , and that death occurred at 11:45 AM from the causes and on the date stated above.		
23A. SIGNATURE Karl Moore M.D.		23B. ADDRESS Church Home Hospital
23C. DATE SIGNED 2/20/50		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb/23/50	24C. NAME OF CEMETERY OR CREMATORY Louisa Park Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Ind.		
25. FUNERAL DIRECTOR Stewart & Gordon Co.		ADDRESS 108 W. North Ave.



450
50 1549
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 1549

1. NAME OF DECEASED (Type or Print) CELIA BLUM		2. DATE OF DEATH FEB. 22, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE DEL. b. COUNTY WILMINGTON	
b. FULL NAME OF (If not in hospital or institution, give street address or location) THE MOUNT 3706 NORTONIA RD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WILMINGTON - DEL.	
Length of stay in Baltimore 7 WEEKS		d. STREET ADDRESS (If rural, give location) 803 VANDEVER AVE.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH DEC. 7 - 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE (In years; last birthday) 70
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOSEPH TONKONOSYI		14. MOTHER'S MAIDEN NAME CHANA HURWITZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT SON - DR. L. V. BLUM		LUM ADDRESS 2122 PARK AVE. BALTO.	
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Gall Bladder DUE TO (A) II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. none DUE TO (B) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 5 mos.			
19a. DATE OF OPERATION 9-4-49		19b. MAJOR FINDINGS OF OPERATION gall Stones and Carcinoma of Gall Bladder	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-4 , 19 49 , to 2-22 , 19 50 , that I last saw the deceased alive on 2-21 , 19 50 , and that death occurred at 12:05 AM. , from the causes and on the date stated above.			
23a. SIGNATURE Louise T. Blum		23b. ADDRESS M. D. 2310 Eutaw Place	
23c. DATE SIGNED 2/22/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE FEB. 23, 1950	
24c. NAME OF CEMETERY OR CREMATORY CHESED SHEL EMEIN CEM.		24d. LOCATION (City, town, or county) (State) WILMINGTON, DEL.	
24e. DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1950		24f. REGISTRAR'S SIGNATURE Wm. J. Fickner	
25. FUNERAL DIRECTOR Wm. J. Fickner & Sons.		ADDRESS NORTH PENNA. AVES.	



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY M. KEATING

2. DATE
OF
DEATH

FEB. 21-1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1261 WILLIAM ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE

MD.

b. COUNTY

c. CITY OR TOWN

BALTIMORE

(If outside corporate limits, write RURAL and give township)

24-03

d. STREET ADDRESS (If rural, give location)

1261 WILLIAM ST.

Length of stay in Baltimore

8 years

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

AUG. 31-1882

9. AGE (In years
last birthday)

67

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR
INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM J. CANNV

14. MOTHER'S MAIDEN NAME

MARY J. BRADLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, oo or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NO

17. INFORMANT

ADDRESS

MARY KITCHNER-1406 WILLIAM ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

- Chronic Endocarditis

3 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B)

Acute Gastritis

3 hrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., lo or
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21e. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3, 1950, to 2/21, 1950, that I last saw the
deceased alive on 2/21, 1950, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

M. D.

1279 William St

2/21/50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

BURIAL

FEB. 23-50

HOLY CROSS CEM.

AACO. MD

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 22 1950

Intington Williams, MD

Elizabeth Hark Inc. 115 E. West St.

CERTIFICATE OF DEATH

M

453
50 1551BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1551
Registered No. 2698

1. NAME OF DECEASED (Type or Print) <i>Sophia Bell Rowland</i>		2. DATE OF DEATH <i>2/19/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Balto.</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1103 Mosher St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. 16-01</i>	
C. Length of stay in Baltimore Yrs. <i>—</i> Mos. <i>—</i> Days <i>—</i>		D. STREET ADDRESS (If rural, give location) <i>1103 Mosher St.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i>	8. DATE OF BIRTH <i>Nov. - 1895</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9. AGE (in years last birthday) <i>54</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	
13. FATHER'S NAME <i>Nicholas Bell</i>		12. CITIZEN OF WHAT COUNTRY? <i>M. d.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i>		14. MOTHER'S MAIDEN NAME <i>Marcellena Wiggins</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT ADDRESS <i>David Bell - 546 Mosher St.</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chn. nephritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>—</i> (C) <i>—</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

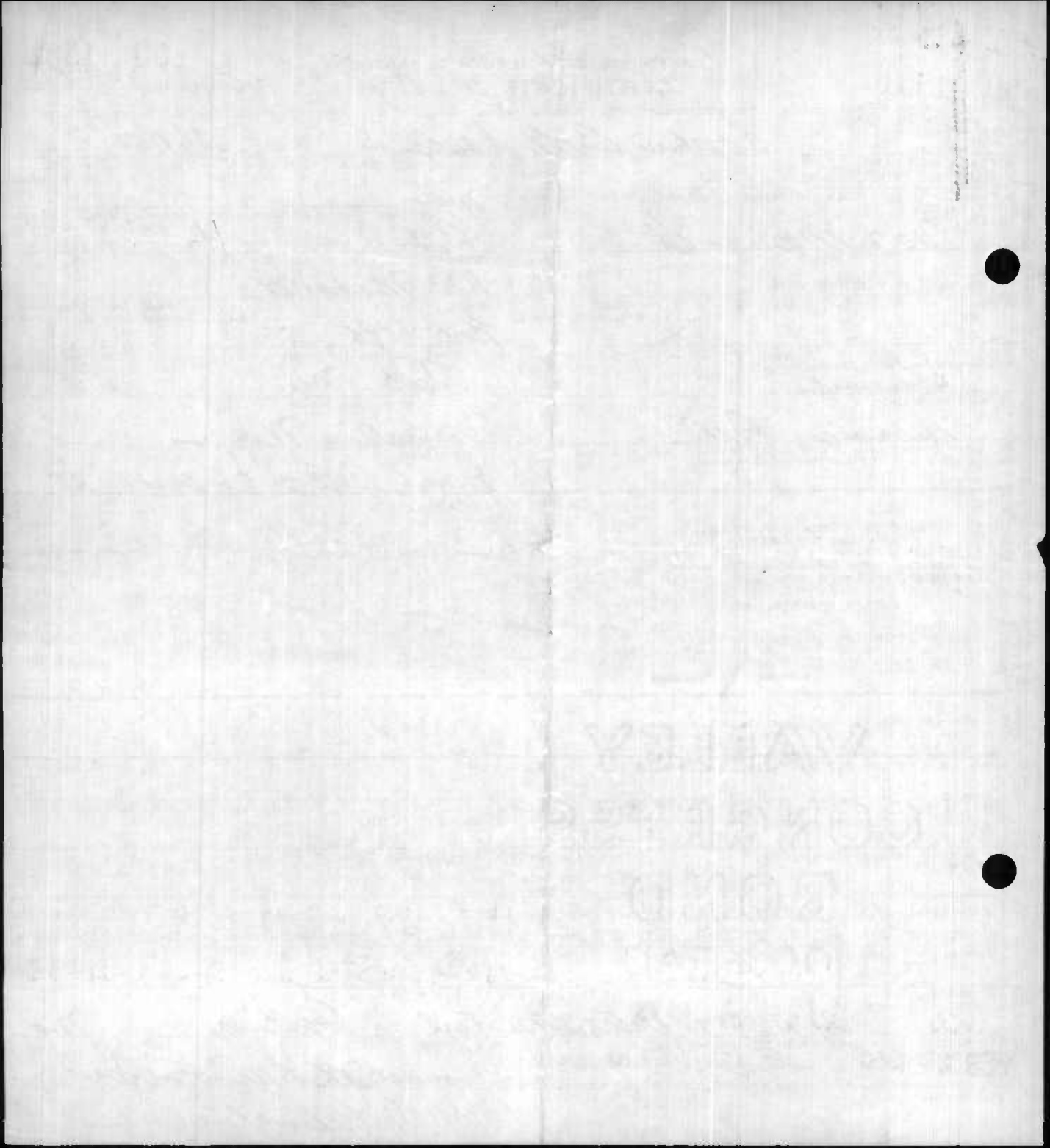
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *2-16-*, 19*50*, to *2-19-*, 19*50*, that I last saw the deceased alive on *2-18-*, 19*50*, and that death occurred at *6:17* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Frank A. Saunders</i> M. D.	23B. ADDRESS <i>1029 N. Stricker St.</i>	23C. DATE SIGNED <i>2-21-50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>B.</i>	24B. DATE <i>2/23/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Park</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Co Md.</i>
DATE RECEIVED BY <i>FEB 23 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	25. FUNERAL DIRECTOR ADDRESS <i>Samuel W. Sullivan Jr</i>	

1310 1011 N. Arlington Ave



200
50 1552BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1552
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Angelo Keys

2. DATE
OF
DEATH

2-19-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

900 N. Fulton Ave.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

900 N. Fulton Ave.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Female

Col.

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

13. FATHER'S NAME

Hannibal Brockington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Florence S.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Nellie Hamilton

17. INFORMANT

James Keys

ADDRESS 900 N. Fulton Ave.

18.

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

1 month

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

2/11/50

Carcinoma of Ovary - Metastasis

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/11/50, 1950, to 2/19/50, 1950, that I last saw the deceased alive on 2/19/50, 1950, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Hannibal Brockington

M. D.

23B. ADDRESS

2243 Madison Ave

23C. DATE SIGNED

2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Feb 22, 1950

Arbutus Memorial

Baltimore

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

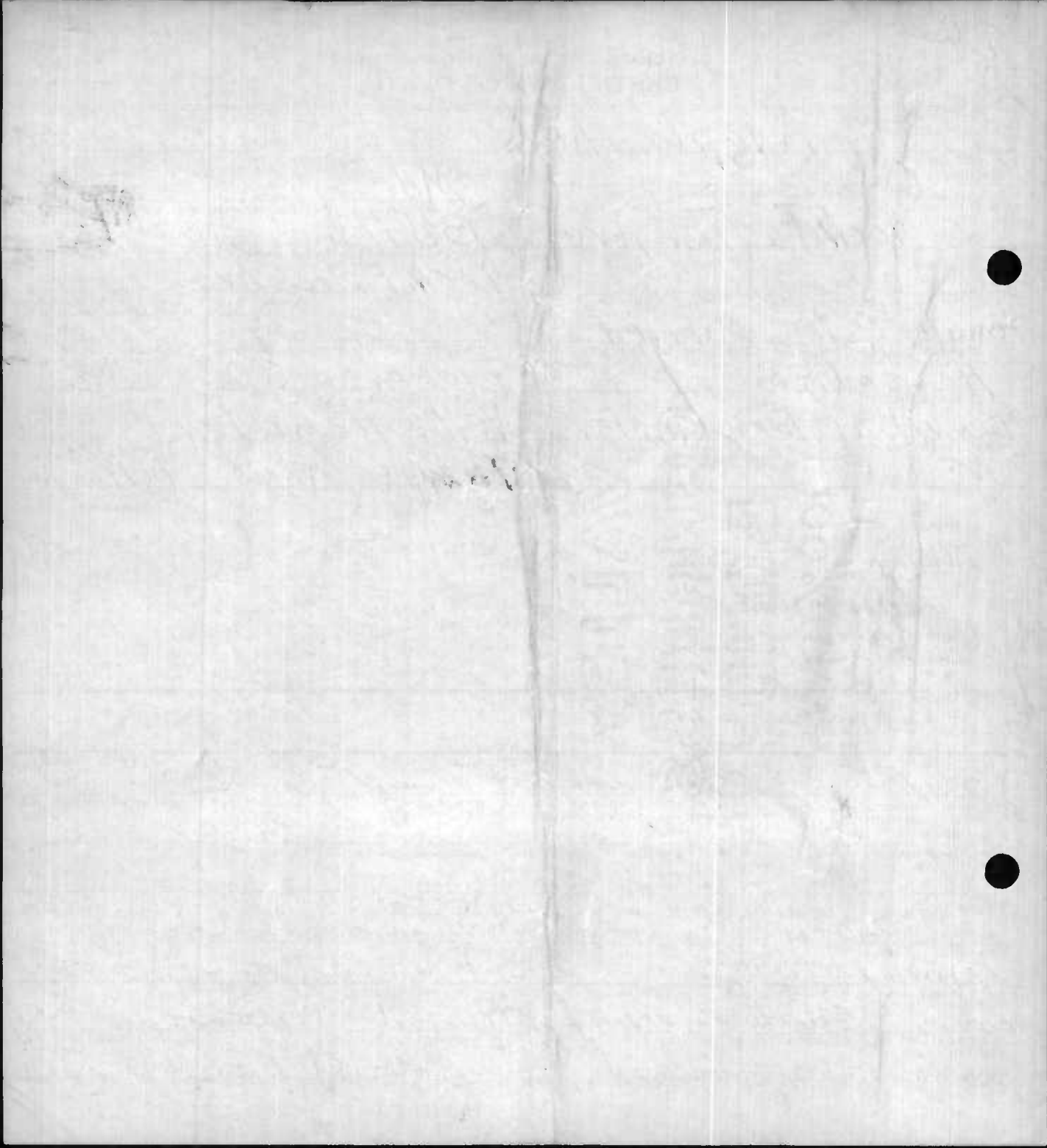
FEB 22 1950

Hannibal Brockington

Mrs. Kate B. Williams

Schmiedt

49a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 1553

BIRTH NO. 1553

1. NAME OF DECEASED (Type or Print) <i>William D. Haugh</i>			2. DATE OF DEATH <i>Feb. 20 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____		
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>University Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
6. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>1526 Hollins St.</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Unknown 1868</i>	9. AGE (in years last birthday) <i>81</i>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Salesman</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Cake Business</i>		
11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Jesse Haugh</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Haugh</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>			16. SOCIAL SECURITY NO. <i>—</i>		
17. INFORMANT <i>Mr. Osean Haugh</i>			ADDRESS <i>1526 Hollins St</i>		

18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>(A) arteriosclerotic Cardio-vascular disease. C Aortic Stenosis and insufficiency</i>					
DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>(B) —</i>					
DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>(C) Pulmonary Tuberculosis -</i>					
19A. DATE OF OPERATION <i>Feb. 20 1950</i>		19B. MAJOR FINDINGS OF OPERATION <i>Left subcostal incision for cardiac massage.</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb 20</i> , 19 <i>50</i> , to <i>Feb 20</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Feb 20</i> , 19 <i>50</i> , and that death occurred at <i>10:45</i> A. M., from the causes and on the date stated above.					
23A. SIGNATURE <i>Dr. Patterson Mack</i>		23B. ADDRESS M. D. <i>University Hospital Balto.</i>		23C. DATE SIGNED <i>Feb 20 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/23/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>					
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 22 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, Jr.</i>		25. FUNERAL DIRECTOR <i>Geo. X. Bayler Jr</i>	
				ADDRESS <i>1512 Hollins St Balto Md</i>	

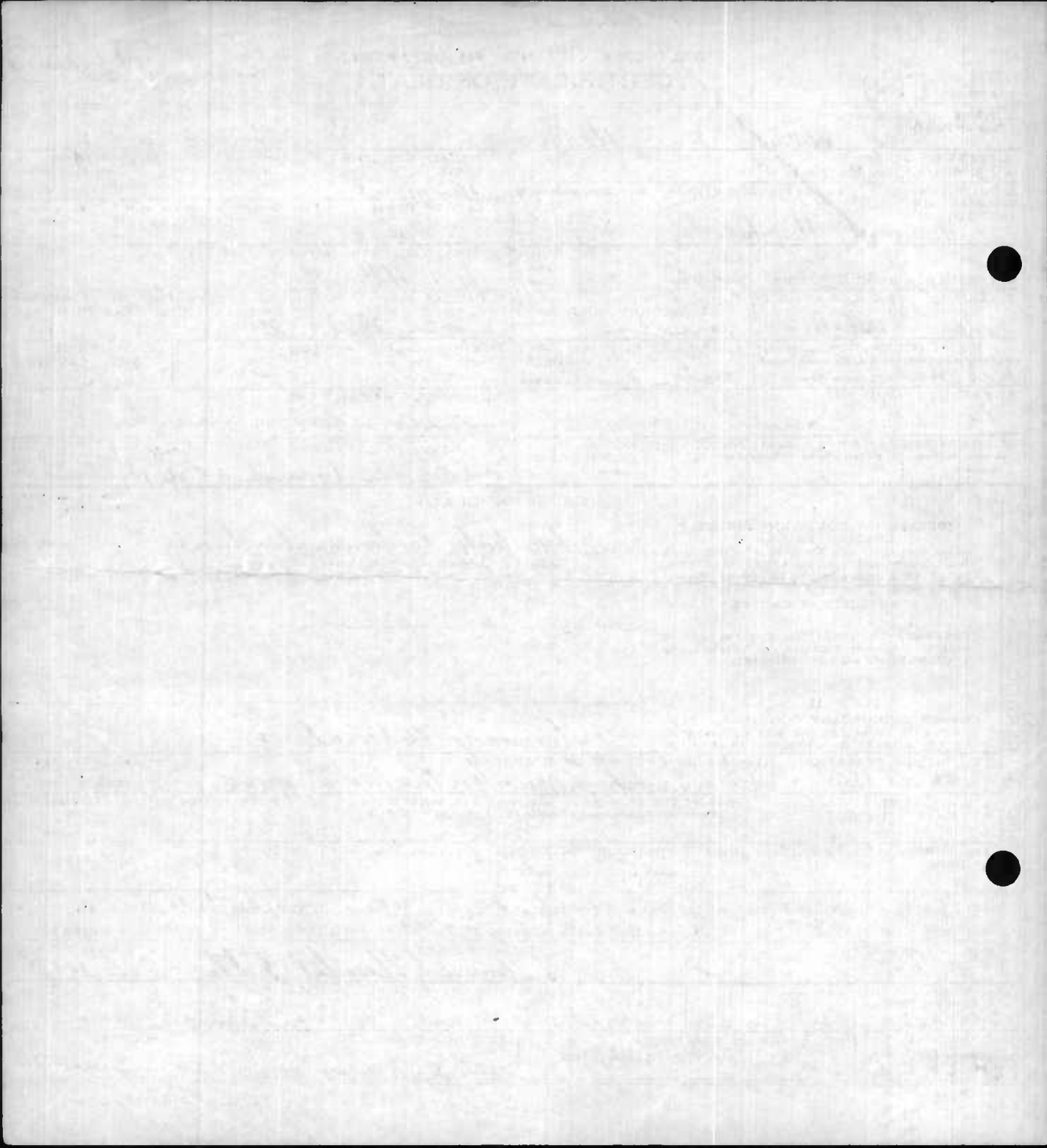
432 XV

13B

Balto Md

correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1554
Registered No. _____

BIRTH NO. 1554

1. NAME OF DECEASED (Type or Print) <i>Dorothy Fuselier</i>		2. DATE OF DEATH <i>Feb. 21, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Mary Hall</i>		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>La</i> B. COUNTY _____	
8. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Eunice</i> Rt. 1 Box 233	
5. Length of stay in Baltimore _____ Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>8-1-31</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>18</i>
11. BIRTHPLACE (State or foreign country) <i>Louis La.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edwin Nailbory -</i>		14. MOTHER'S MAIDEN NAME <i>Amy Miller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>754.4</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hemorrhage</i> (A) _____ DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Aneurysm of aorta</i> (B) _____ DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Resection of coarctation of aorta "Pregnancy, intrauterine death"</i> (C) _____		
19A. DATE OF OPERATION <i>2/14/50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Aneurysm of aorta</i>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>1-24-</i> , 19 <i>50</i> , to <i>2-21-</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>2-21-</i> , 19 <i>50</i> , and that death occurred at <i>3:00 P.M.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Richard F. Kieffer Jr.</i>	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>2/21/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	24B. DATE <i>2/22-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>EUNICE, LOUISIANA</i>
24D. LOCATION (City, town, or county) (State) <i>2008 ORLEANS</i>	25. FUNERAL DIRECTOR <i>ULLRICH FUNERAL HOME</i>	ADDRESS

CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

1911

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

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NOTA: CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1555

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Frederick Rodis

2. DATE OF DEATH
Feb. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

304 W. Monument St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 11-03

D. STREET ADDRESS (If rural, give location)
304 W. Monument St.

Length of stay in Baltimore

5. SEX
M

6. COLOR OR RACE
W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH
Aug. 13, 1879

9. AGE (In years last birthday)
70

10 Under 1 Year Months Days 11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
electrician

10B. KIND OF BUSINESS OR INDUSTRY
Elec Appl. Mfgs

11. BIRTHPLACE (State or foreign country)
Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
Unknown

14. MOTHER'S MAIDEN NAME
Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. Junia B. Rodis, 304 W. Monument St

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion
DUE TO Anterior-splenic C. V. Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) (over)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE
Earl L. Royer

23B. CHIEF MEDICAL EXAMINER ☐ 23C. DATE SIGNED
M.D. MEDICAL INVESTIGATOR ☒ 21 Feb 50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE
2/23/50

24C. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem.

24D. LOCATION (City, town, or county) (State)
Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR
FEB 22 1950

REGISTRAR'S SIGNATURE
Wilmington Williams, Md.

25. FUNERAL DIRECTOR
Wm. J. Tickner & Sons

ADDRESS
Balto., Md.

Statistical purposes only - Do not add to transcript

Chemical analysis disclosed
the fact that amite
alcoholism should be added
to cause of death

See Document File 50-1555

4-19-50

Es.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 1556

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JOHN WILLIAM HUGHES

2. DATE
OF
DEATH

Feb. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

D.C.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Washington

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

2821 Winchester St.

D. STREET ADDRESS (If rural, give location)
McComb St., N. W.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
single

8. DATE OF BIRTH

Oct. 9, 1885

9. AGE (In years last birthday)

64

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Hotel

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

J. Robert Hughes

14. MOTHER'S MAIDEN NAME

Mary E. Scrivenor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, on or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. James F. Stevens, Sr. 2821 Winchester St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) *Carcinoma of the End of Stomach*
(B) *Malignant Cachexia*
(C) *Cachexia*

not 9-19-49

19A. DATE OF OPERATION

not 9-19-49

19B. MAJOR FINDINGS OF OPERATION

Carcinoma

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 2, 1950, to Feb 20, 1950, that I last saw the deceased alive on Feb 15, 1950, and that death occurred at 12:35 p.m. from the causes and on the date stated above.

23A. SIGNATURE

John J. Mahoney

23B. ADDRESS

M. D. 1219 DeBlanc Road N 2/21/50

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/22/50

24C. NAME OF CEMETERY OR CREMATORY

Freedom Cem.

24D. LOCATION (City, town, or county) (State)

Freedom, Md.

DATE RECEIVED BY LOCAL REGISTRAR

FEB 22 1950

REGISTRAR'S SIGNATURE

Thurston M. Mahoney, M.D.

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.

VS 150

26687

5 5 0 0 2 1 5 5 0

46B

MEDICAL CERTIFICATION

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE

January 10, 1901

REPORT

OF THE

ATTORNEY GENERAL
FOR THE YEAR 1900

ALBANY:

1901

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY HELEN SMITH

2. DATE
OF
DEATH

Feb. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Md.

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

3604 Spaulding Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

27-18

D. STREET ADDRESS (If rural, give location)
3604 Spaulding Ave.

6. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
widowed

8. DATE OF BIRTH

May 12, 1852

9. AGE (In years last birthday)

97

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Pennington

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mr. Frank P. Smith

Adams, D. C. 14th & G. Sts

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Senility

10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Bronchitis - pneumonia

2 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1944 to Feb. 20, 1950, that I last saw the deceased alive on Feb. 19, 1950, and that death occurred at 4 A. M., from the causes and on the date stated above.

23A. SIGNATURE

J. E. C. Wells

M. D.

23B. ADDRESS

4100 Edmondson Ave.

23C. DATE SIGNED

2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

2/23/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county) (State)

Woodlawn, Md.

DATE RECEIVED BY

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

Wm. J. Tickner & Sons

WM. J. TICKNER & SONS

Balto., Md.

RECEIVED BY THE
CITY OF BEAT

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1558
Registered No.

550
BIRTH NO. 1558

1. NAME OF DECEASED (Type or Print) <i>William W Hayman</i>			2. DATE OF DEATH <i>2/20/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore City Maryland</i> B. FULL NAME OF HOSPITAL OR INSTITUTION <i>West Baltimore General</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>9017 Hartford Rd #14</i>		
5. SEX <i>M</i>			6. COLOR OR RACE <i>W</i>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S</i>			8. DATE OF BIRTH <i>6/19/38</i>		
9. AGE (In years, last birthday) <i>11</i>			10. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School</i>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>John H. Hayman</i>			14. MOTHER'S MAIDEN NAME <i>Margaret Emge</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mr. J. H. Hayman</i>			ADDRESS <i>9017 Hartford Rd.</i>		

18. <i>580.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(A) <i>Possible Salicylate Intoxication</i>			
		(B) <i>Possible Belladonna Intoxication</i>			
		(C) <i>Possible Encephalitis</i> <i>(Cleared by Medical Examiner)</i> <i>(over)</i>			

19A. DATE OF OPERATION <i>2</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *2/19*, 19*50*, to *2/20*, 19*50*, that I last saw the deceased alive on *2/20*, 19*50*, and that death occurred at *11 45* p.m., from the causes and on the date stated above.

23A. SIGNATURE <i>Orlyn H. Wood</i>	23B. ADDRESS <i>West Balt. General Hosp.</i>	23C. DATE SIGNED <i>2/21/50</i>
--	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2/24/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>	24D. LOCATION (City, town, or county) (State) <i>Taylor Ave</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 22 1950</i>	REGISTRAR'S SIGNATURE <i>Timothy Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Margaret J. Blight</i>	ADDRESS <i>6009 Hartford Rd</i>

CERTIFICATION APPROVED BY

Dr. Wm. Kammer per

R. S. Fisher M.D.

CHIEF OR ASST. MEDICAL EXAMINER.

Chemical analysis failed to show toxic quantities of salicylate although there was a therapeutic level. Belladonna was absent. Microscopy showed an extensive fatty degeneration of liver with widespread central necrosis. The patient died in acidosis and it should probably be signed "acidosis due to hepatic necrosis" the etiology of which is unknown.

59107

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

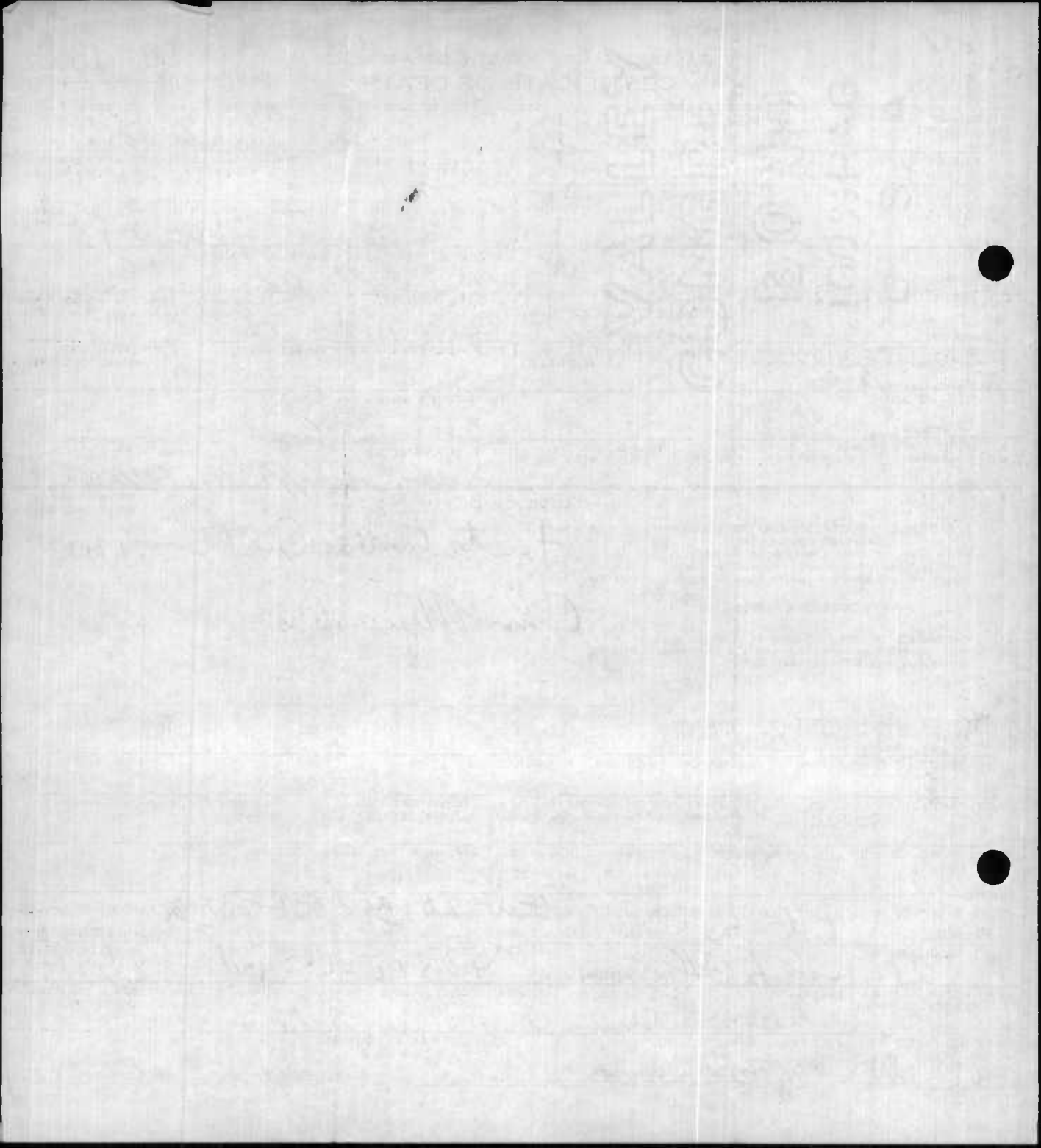
50 1559
Registered No.

160
BIRTH NO. 1559

1. NAME OF DECEASED (Type or Print) <i>Elora M. Schaffer</i>			2. DATE OF DEATH <i>Feb. 20, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>4027 Falls Rd.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> <i>13-07</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>4027 Falls Rd.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug 30, 1897</i>	9. AGE (In years, last birthday) <i>52</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>John Eck</i>			14. MOTHER'S MAIDEN NAME <i>Elora E. Wright</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Elora M. Schaffer, 4027 Falls Rd.</i>		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Acute Cardiac Dilatation</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 Hr.</i>
DUE TO (A)			
DUE TO (B) <i>Chr Myocarditis</i>			
DUE TO (C)			
<p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb 20, 1950</i> to <i>Feb 20, 1950</i> that I last saw the deceased alive on <i>Feb 20, 1950</i> and that death occurred at <i>m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Edward L. Horman M. D.</i>		23B. ADDRESS <i>4037 Falls Rd.</i>	23C. DATE SIGNED <i>2/22/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Feb 23, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park</i>	24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 22 1950</i>	REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Paul E. Schenck</i>	ADDRESS <i>7615-17 Chestnut Ave.</i>

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1560

BIRTH NO. 50 1560

1. NAME OF DECEASED (Type or Print) <i>We. Marie</i>		2. DATE OF DEATH <i>Feb. 19, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Agnes Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 23-02</i>	
Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>1522 S. Charles St.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Oct. 10, 1899</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <i>John H. Russell</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <i>Catherine McElister</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Tom Russell</i>	
17. ADDRESS			

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Crushed Skull.</i>	CAUSE OF DEATH <i>Crushed Skull.</i>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Street</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Wilkins and Caldwell Aves. 25-1</i>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Feb. 19, 1950 7 P.m.</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>Pedestrian struck by auto</i>

22. I certify that I took charge of the remains described above, held an *Insp. & Inq.* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE
Earl L. Royce

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
M.D. *Feb. 20, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)
2/23/50

24B. DATE
2/23/50

24C. NAME OF CEMETERY OR CREMATORY
Cooked Hill

24D. LOCATION (City, town, or county) (State)
1702

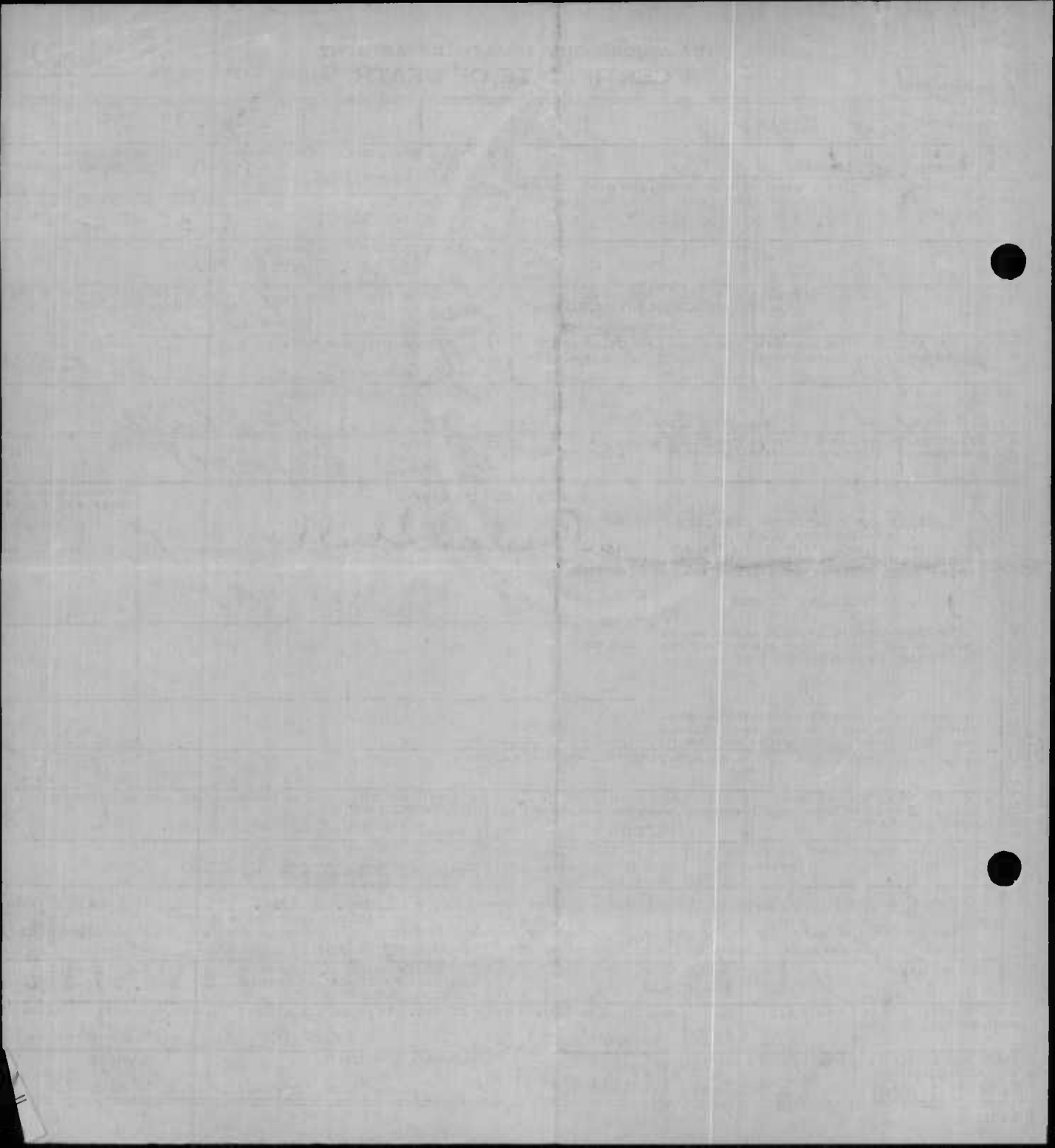
DATE RECEIVED BY LOCAL REGISTRAR
FEB 22 1950

REGISTRAR'S SIGNATURE
Wilmington Williams

25. FUNERAL DIRECTOR
Wilmington Williams

ADDRESS
1702

VS 151



600

LOAR

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1561

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Loar, William Reide Jr.

2. DATE
OF
DEATH

2/19/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Md B. COUNTY BaltoB. FULL NAME OF
HOSPITAL OR
INSTITUTION

Sinei Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Middle River

C. Length of stay in Baltimore

Yrs.
Mos.
DaysD. STREET ADDRESS (If rural, give location)
514 Middle River Rd

5. SEX

male

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 31-1868

9. AGE (In years, last birthday)

II Under 1 Year Months: Days II Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

Own

11. BIRTHPLACE (State or foreign country)

Allegheny Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Nelson Loar

14. MOTHER'S MAIDEN NAME

Ellen Jane Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. J. M. Loar - Same as Above

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic Heart Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Benign prostatic hypertrophy and uremia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2/17 1950 to 2/19 1950, that I last saw the deceased alive on 2/19 1950 and that death occurred at 11:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 22 1950

Huntington Williams, M.D.

John S. Connolly - 418 Eastern Ave

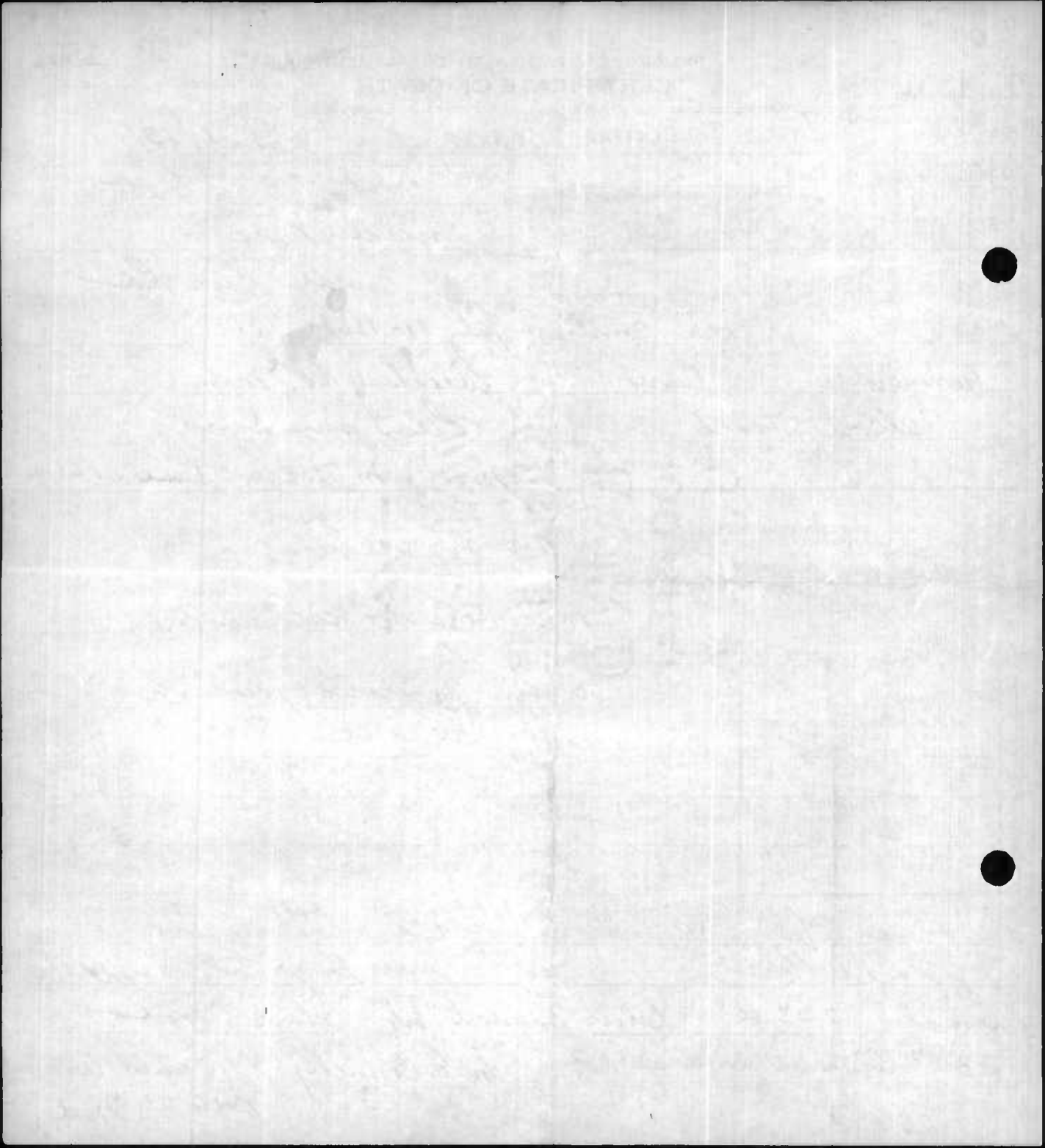
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000VV

1561

Balto 21, Md.

MEDICAL CERTIFICATION



220
50 1562BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH174 50 1562
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Julia Miceilla

2. DATE
OF
DEATH

Feb 21-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3523 Ailsa Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION)

Ailsa location

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 27-01

D. STREET ADDRESS (If rural, give location)

3523 Ailsa Ave.

c. Length of stay in Baltimore

46 yrs

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Feb 17-1904

9. AGE (In years last birthday)

46

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cherry

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

Yes

13. FATHER'S NAME

Julius Rupp

14. MOTHER'S MAIDEN NAME

L. Wischelle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

705-05-3019

17. INFORMANT

Anthony Miceilla

ADDRESS

Ailsa

3523 Ailsa Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma, uterus

4 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

None (inoperable)

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/26/1949, to 2/21/1950, that I last saw the deceased alive on 2/21/1950, and that death occurred at 1:27 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles V. Sevcik

M. O.

23B. ADDRESS

3601 Ailsa Ave

23C. DATE SIGNED

2/21/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Feb 25-50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem

24D. LOCATION (City, town, or county)

North Ave Balto Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams

25. FUNERAL DIRECTOR

Joseph Lagunskas Jr

ADDRESS

602 Wash.

FEB 22 1950

VS 150

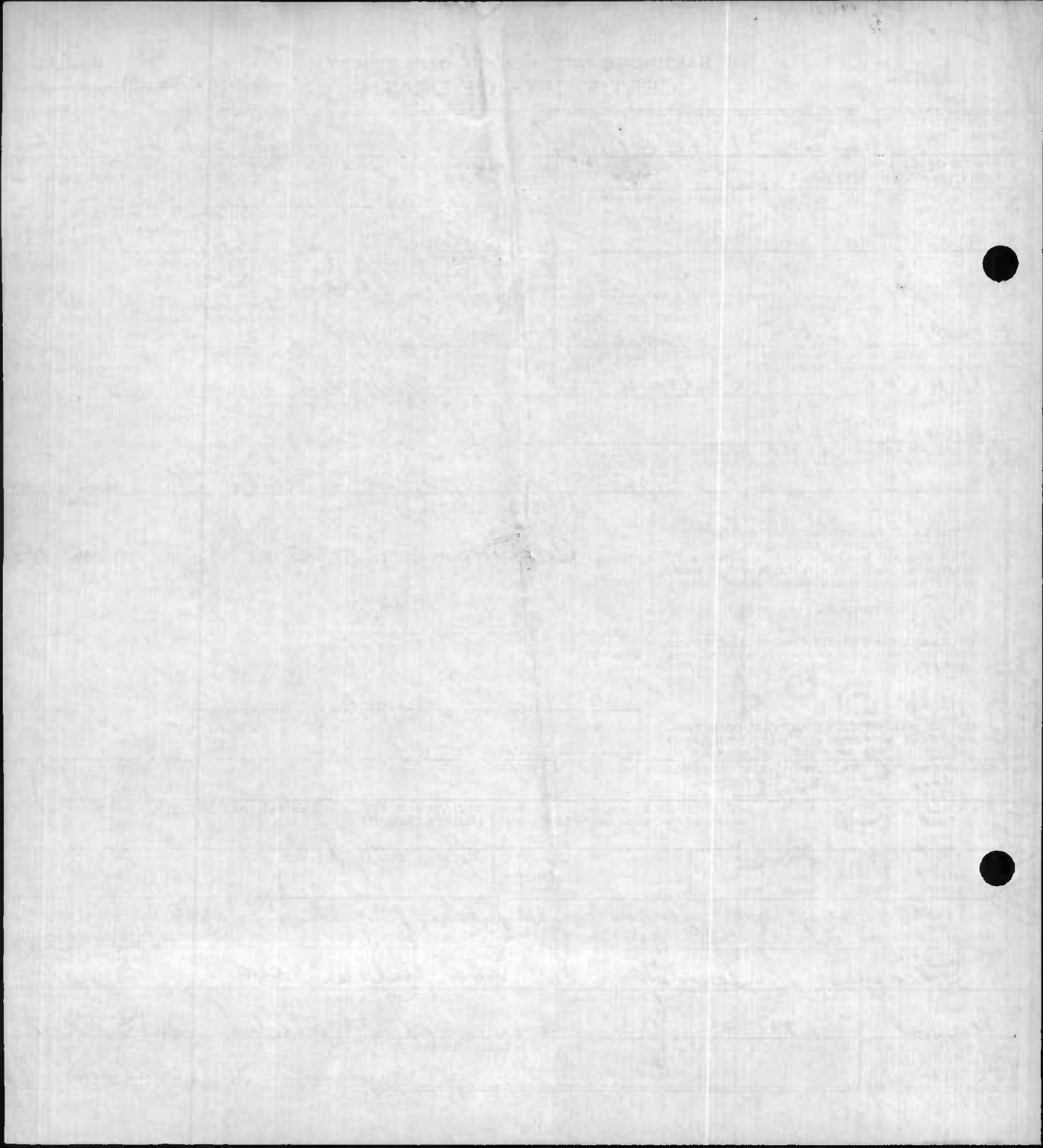
26647

C.V. Sevcik, MD

48 R

1844

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED
 (Type or Print)

ELIZABETH ELLEN STARR

2. DATE
 OF
 DEATH

FEB. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
 HOSPITAL OR INSTITUTION

EDGEWOOD NURSING HOME

6000 BELLONA AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO.

27-14

D. STREET ADDRESS (If rural, give location)

114 WOODLAWN ROAD

Length of stay in Baltimore

50 YRS.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

APR. 12, 1859

9. AGE (In years, last birthday)

90

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MUSICIAN

10B. KIND OF BUSINESS OR INDUSTRY

MUSIC COUNSELOR

11. BIRTHPLACE (State or foreign country)

BALTO. Co., MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

SAMUEL W. STARR

14. MOTHER'S MAIDEN NAME

CATHERINE NORTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MRS. JOHN S. MCKENZIE TOWSON, MD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

6 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis

sub.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Fractured Hip

3 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

nursing home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

100 W. Coldspring Lane

27/11

21D. TIME (Month) (Day) (Year) (Hour)

November 28, 1949 ?p m.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slipped and fell to the floor

22. I hereby certify that I attended the deceased from Oct 1, 1949, to Feb 18, 1950, that I last saw the deceased alive on Feb 18, 1950, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John S. Breen, Jr. M.D.

23B. ADDRESS

Towson - 4 - Md

23C. DATE SIGNED

2/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

FEB. 23, 1950

24C. NAME OF CEMETERY OR CREMATORY

GREENMOUNT

24D. LOCATION (City, town, or county)

BALTO.

MD.

DATE RECEIVED BY LOCAL REGISTRAR

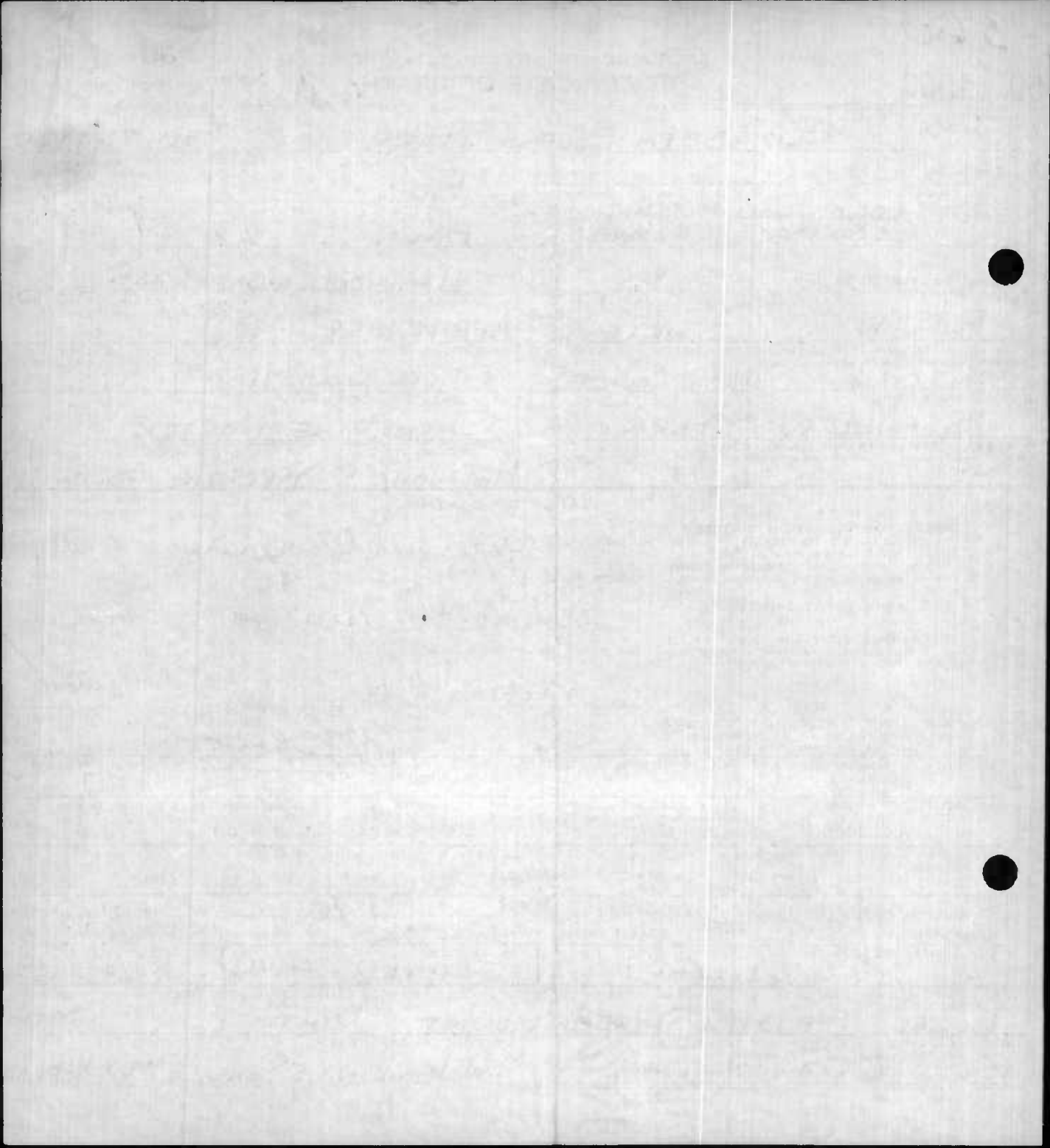
REGISTRAR'S SIGNATURE

William H. Jenkins, Jr.

25. FUNERAL DIRECTOR

ADDRESS

H. W. JENKINS & Sons Co. 4905 York Rd



BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

Registered No. 50 1564

500
 1564

1. NAME OF DECEASED (Type or Print) Clara Kohn			2. DATE OF DEATH 2/22/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland 2424 Rogers Ave.			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Baltimore Md. B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2424 Rogers Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md. 27-15		
C. Length of stay in Baltimore 77 years			D. STREET ADDRESS (If rural, give location) 2424 Rogers Ave.		
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Nov. 29 1872	9. AGE (In years last birthday) 77	10. Under 1 Year Months: Days 3 24
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY same	11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Moses Strauss			14. MOTHER'S MAIDEN NAME Caroline ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. Martin Kohn 2424 Rogers Ave.		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carcinoma, probably breast or thyroid	CAUSE OF DEATH (A) Metastatic Carcinoma, probably breast or thyroid DUE TO	INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypotension	(B) Hypotension DUE TO	2 days
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Dehydration	(C) Dehydration DUE TO	8 days

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb 15, 1950**, to **Feb 22, 1950**, that I last saw the deceased alive on **Feb 21, 1950**, and that death occurred at **5 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE Joseph Cohen	23B. ADDRESS 5901 Park Heights Ave	23C. DATE SIGNED 2/22/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb 23/1950	24C. NAME OF CEMETERY OR CREMATORY Har Sinai	24D. LOCATION (City, town, or county) (State) Edman ave mg place
DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1950	REGISTRAR'S SIGNATURE David S. Williams	25. FUNERAL DIRECTOR ADDRESS David S. Williams 1902 E. ...	

STATE OF NEW YORK
CERTIFICATE OF DEATH

1911

1912

1913

1914

1915

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1918

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1920

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1926

1927

1928

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1937

1938

1939

1940

1941

1942

1943

625
50 1565BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1565

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BIRKENWALD, ITTA			2. DATE OF DEATH FEB 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
B. FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-07B		
Length of stay in Baltimore UNK.			D. STREET ADDRESS (If rural, give location) 3025 WINDSOR AVE.		
5. SEX F	6. COLOR OR RACE JEWSH	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH MAR 19, 1880	9. AGE (In years last birthday) 69	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME KOSSUTH BIRKENWALD		
14. MOTHER'S MAIDEN NAME SOPHIE ROSENSTOCK			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		
16. SOCIAL SECURITY NO. —			17. INFORMANT MRS. MYRTLE ISEMAN		
18. ADDRESS WASHINGTON, D.C.			19. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —		

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **MYOCARDIAL INFARCTION****10 DAYS**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **ARTERIOSCLEROTIC CORONARY THROMBOSIS****10 DAYS**

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) **MULTIPLE OLD CEREBRO-VASCULAR ACCIDENTS**

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2/13**, 19**50**, to **2/21**, 19**50**, that I last saw the deceased alive on **2/21**, 19**50**, and that death occurred at **5:40 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE J. Frank Supple, III	23B. ADDRESS Union Memorial Hosp.	23C. DATE SIGNED 2/21/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb. 23, 1950	24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship	24D. LOCATION (City, town, or county) (State) Philadelphia Penn
DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1950		REGISTRAR'S SIGNATURE Heinzinger	25. FUNERAL DIRECTOR David Bondheiser
		ADDRESS 1902 E. 1st St	

STATE OF TEXAS

COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE

STATE OF TEXAS

IN RE: THE ESTATE OF

JOHN A. BROWN, DECEASED

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

VS.

JOHN A. BROWN, JR.,

ADMINISTRATOR

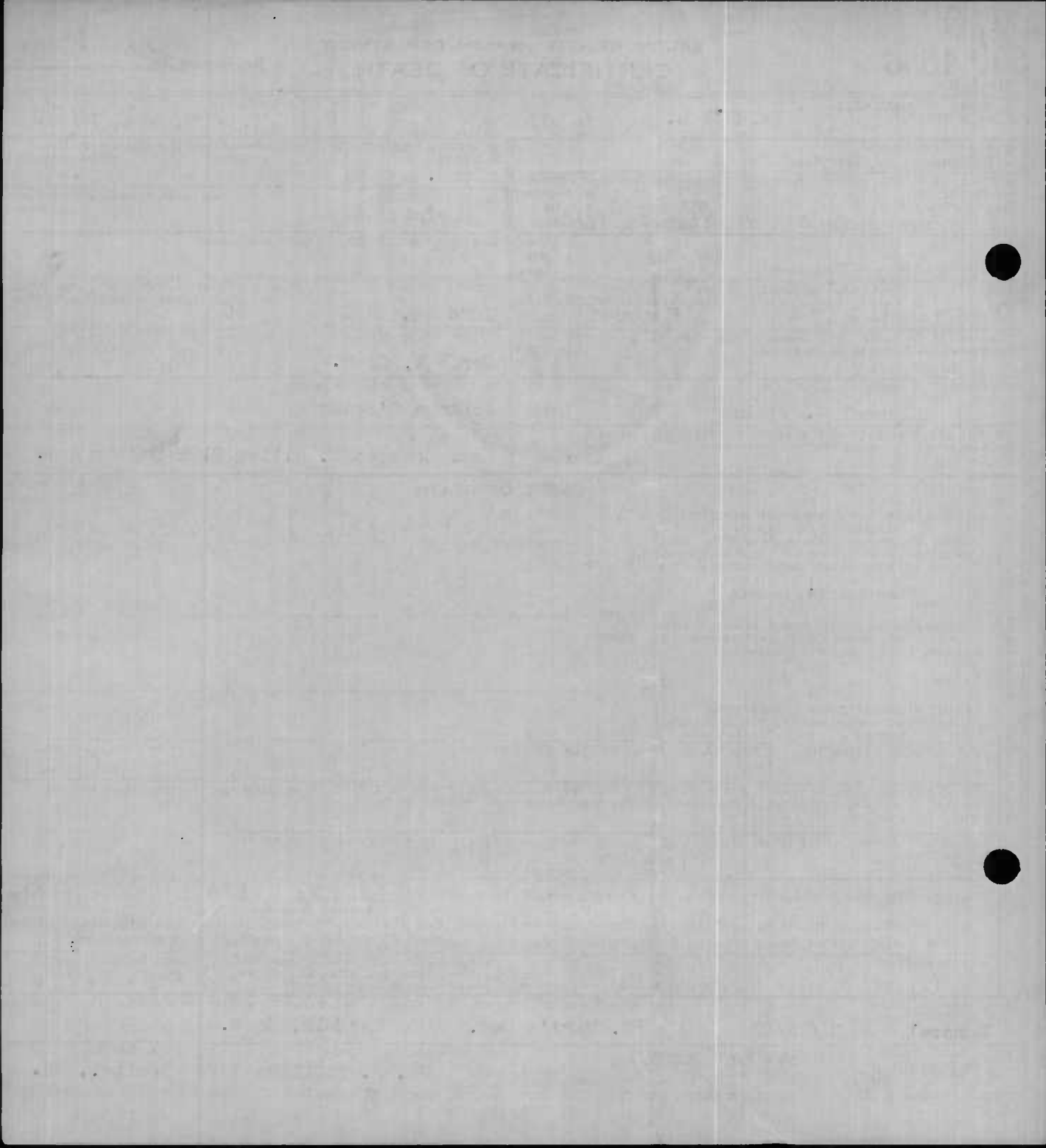
431
50 1566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1566
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) KATHRYN L. Hildebrand		2. DATE OF DEATH Feb. 22, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Conn. B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Norfolk			
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) divorced		8. DATE OF BIRTH June 24, 1893	9. AGE (In years last birthday) 56
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Norfolk, Conn.	
13. FATHER'S NAME Michael W. Dillon		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Mrs. Charles W. Miller 2102 Dobler Ave.	

18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary Disease (A) DUE TO II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Wm. H. Kammner, Jr. M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>		23C. DATE SIGNED Feb. 22, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 2/23/50		24C. NAME OF CEMETERY OR CREMATORY St. Mary's Cem.	
24D. LOCATION (City, town, or county) (State) Norfolk, Conn.		25. FUNERAL DIRECTOR WM. J. TICKNER & SONS		ADDRESS Balto., Md.	



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1567**

BIRTH NO. 1567

1. NAME OF DECEASED (Type or Print) <i>Sarah Lusby</i>			2. DATE OF DEATH <i>2/21/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Anne Arundel</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>West Baltimore General Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Manhattan Beach</i>		
Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>Lexington P.O. Md</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>m</i>	8. DATE OF BIRTH <i>Oct 12, 1875</i>		9. AGE (In years last birthday) <i>74</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Hegakiah Hlison</i>			14. MOTHER'S MAIDEN NAME <i>Barbara J. Harrison</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>B. R. Lusby 2316 Musher St</i>		

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of the pancreas</i> DUE TO		<i>?</i>
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <i>2/23/50</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Dec. 15th*, 1949, to *Feb. 21st*, 1950, that I last saw the deceased alive on *Feb. 21st*, 1950, and that death occurred at *12:17 Am.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Katharine V. Kimo</i>	23B. ADDRESS <i>West Balto Gen Hosp</i>	23C. DATE SIGNED <i>2/21/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2/23/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Green Haven Cem. Annapolis Blvd</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 23 1950</i>	REGISTRAR'S SIGNATURE <i>John F. Henry</i>	25. FUNERAL DIRECTOR ADDRESS <i>715 Light St.</i>

STATE OF TEXAS
COUNTY OF DALLAS

BEFORE ME, the undersigned authority, on this _____ day of _____, 20____, personally appeared _____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 20____.

Notary Public in and for the State of Texas

My commission expires this _____ day of _____, 20____.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1568
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

FRED (Frederick)

TRUSTY

2. DATE
OF
DEATH

February 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

917 Madison Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

917 Madison Avenue

Length of stay in Baltimore

15 Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug 19, 1893

9. AGE (In years last birthday)

56

10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Canning House

11. BIRTHPLACE (State or foreign country)

Centerville Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Charles Trusty

14. MOTHER'S MAIDEN NAME

Ratiee Ringgold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes World War I

16. SOCIAL SECURITY NO.

216-12-0420

17. INFORMANT

Perry Trusty - Centerville Md

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Paul H. Roy

23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....

23C. DATE SIGNED 2-20-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/23/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

FEB 23 1950

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

A. Halstead - 918 -

ADDRESS

108 Melvin Steel Ave.

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

City of _____

State of _____

Decedent's Name _____

Age _____

Sex _____

Marital Status _____

Place of Birth _____

Date of Death _____

Time of Death _____

Place of Death _____

Cause of Death _____

Signature of Physician _____

Signature of Coroner _____

Signature of Registrar _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

616
1569BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1569

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

C. BESSIE GERBER

2. DATE
OF
DEATH

2-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

3813 Strathmore Ave

Yrs.

Mos.

Days

C. Length of stay in Baltimore

57

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Samuel

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md

B. COUNTY

before admission)

C. CITY OR TOWN

Baltimore 27-20

D. STREET ADDRESS (If rural, give location)

3813 Strathmore Ave

8. DATE OF BIRTH

9. AGE (In years

83

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Lith

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Hannah

17. INFORMANT

ADDRESS

Ludell Gerber 3813 Strathmore Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Pulmonary Edema

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Heart Failure

5 days

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Hypertensive Cardiovascular Dis.
Paraplegia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

1945, to 2-22, 1950, that I last saw the

deceased alive on 2-22, 1950, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Albert Gubitzky, M.D.

M. D.

23B. ADDRESS

2217 South Road

23C. DATE SIGNED

2/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

2-28-50

24C. NAME OF CEMETERY OR CREMATORY

Maaree Tfelok

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY
LOCAL REGISTRAR

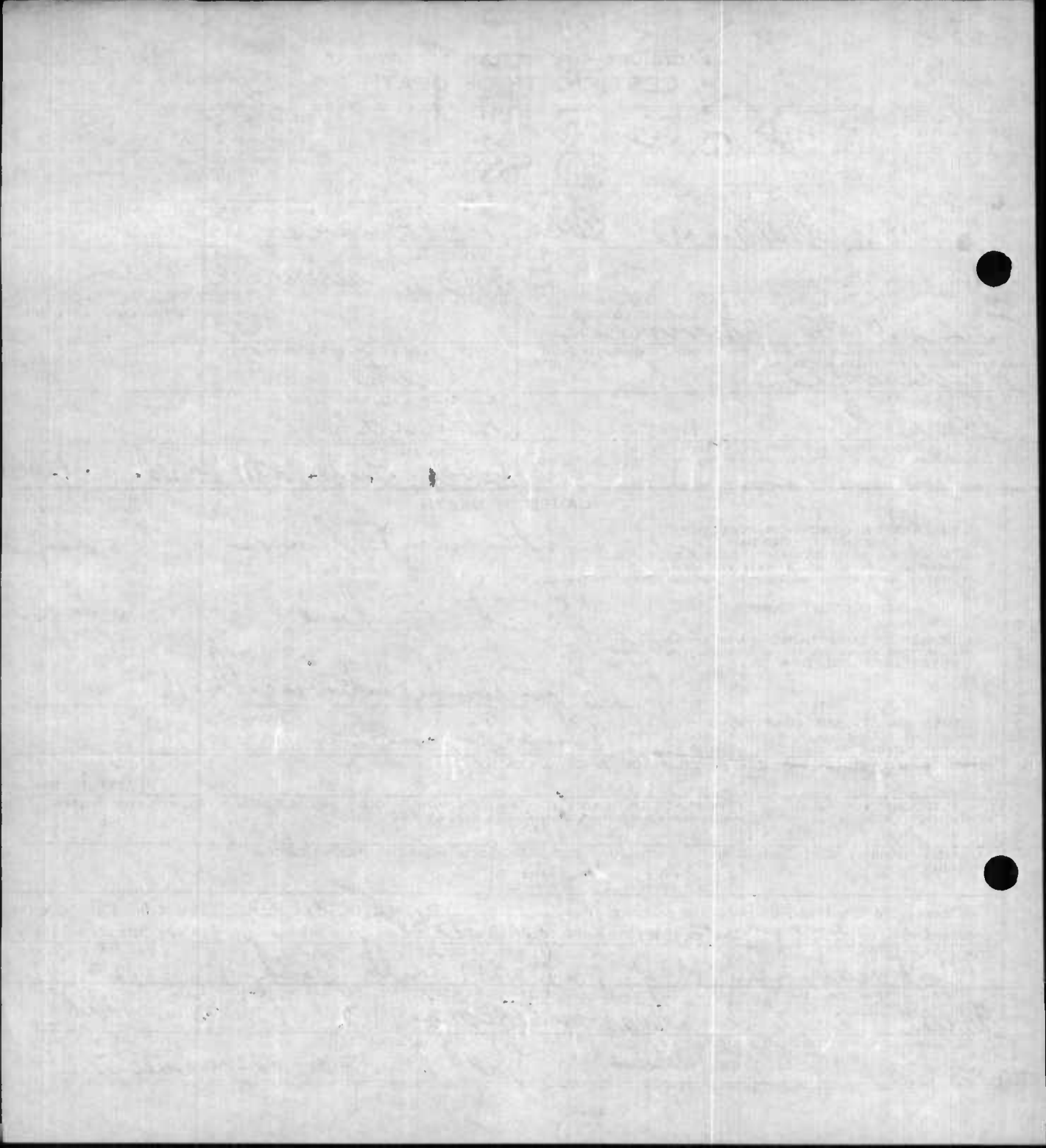
REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

Jack Lewis Inc 2100 Canton Rd

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1570
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) OTTO KOSLOWSKY		2. DATE OF DEATH Feb. 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE NJ B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION US Marine Hospital Wyman Pk. Drive & 31st St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bogota	
D. STREET ADDRESS (If rural, give location) 349 Elm Avenue		5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	
6. COLOR OR RACE W <input checked="" type="checkbox"/> O <input type="checkbox"/>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 3/27/77		9. AGE (In years; last birthday) 72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief steward		10B. KIND OF BUSINESS OR INDUSTRY Seafarer	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Otto Koslowsky		14. MOTHER'S MAIDEN NAME Elizabeth Rosebrook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 086-14-6388	
17. INFORMANT Records- US Marine Hospital, Balto, Md.		ADDRESS _____	

<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) Coronary artery sclerosis Myocardial fibrosis DUE TO _____</p> <p>(B) Squamous cell carcinoma nasopharynx Pulmonary edema, severe DUE TO _____</p> <p>(C) Bronchopneumonia</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>Years</p> <p>Months</p> <p>Hours</p> <p>Days</p>

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 19, 1950, to Feb. 17, 1950, that I last saw the deceased alive on Feb. 17, 1950, and that death occurred at 10:05P m., from the causes and on the date stated above.

23A. SIGNATURE John L. Wilson, Medical Director M.D.	23B. ADDRESS US Marine Hospital, Balto, Md.	23C. DATE SIGNED 2/20/50
--	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 2/23/50	24C. NAME OF CEMETERY OR CREMATORY MT. CARMEL	24D. LOCATION (City, town or county) (State) BALTO. MD.
DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR Lillig & Ziller Inc. Balto.

45F

STATEMENT OF DEATH
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Burial		18. Signature of Interment	
19. Signature of Burial		20. Signature of Interment		21. Signature of Burial	
22. Signature of Interment		23. Signature of Burial		24. Signature of Interment	
25. Signature of Burial		26. Signature of Interment		27. Signature of Burial	
28. Signature of Interment		29. Signature of Burial		30. Signature of Interment	
31. Signature of Burial		32. Signature of Interment		33. Signature of Burial	
34. Signature of Interment		35. Signature of Burial		36. Signature of Interment	
37. Signature of Burial		38. Signature of Interment		39. Signature of Burial	
40. Signature of Interment		41. Signature of Burial		42. Signature of Interment	
43. Signature of Burial		44. Signature of Interment		45. Signature of Burial	
46. Signature of Interment		47. Signature of Burial		48. Signature of Interment	
49. Signature of Burial		50. Signature of Interment		51. Signature of Burial	
52. Signature of Interment		53. Signature of Burial		54. Signature of Interment	
55. Signature of Burial		56. Signature of Interment		57. Signature of Burial	
58. Signature of Interment		59. Signature of Burial		60. Signature of Interment	
61. Signature of Burial		62. Signature of Interment		63. Signature of Burial	
64. Signature of Interment		65. Signature of Burial		66. Signature of Interment	
67. Signature of Burial		68. Signature of Interment		69. Signature of Burial	
70. Signature of Interment		71. Signature of Burial		72. Signature of Interment	
73. Signature of Burial		74. Signature of Interment		75. Signature of Burial	
76. Signature of Interment		77. Signature of Burial		78. Signature of Interment	
79. Signature of Burial		80. Signature of Interment		81. Signature of Burial	
82. Signature of Interment		83. Signature of Burial		84. Signature of Interment	
85. Signature of Burial		86. Signature of Interment		87. Signature of Burial	
88. Signature of Interment		89. Signature of Burial		90. Signature of Interment	
91. Signature of Burial		92. Signature of Interment		93. Signature of Burial	
94. Signature of Interment		95. Signature of Burial		96. Signature of Interment	
97. Signature of Burial		98. Signature of Interment		99. Signature of Burial	
100. Signature of Interment		101. Signature of Burial		102. Signature of Interment	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) *Charles C. Giesey*

2. DATE
OF
DEATH *2/21/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore City*

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION *West Baltimore General Hosp*

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE *Maryland* B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore *9-08*

D. STREET ADDRESS (If rural, give location)
1903 Homewood Ave

Length of stay in Baltimore *Life*

5. SEX *M*

6. COLOR OR RACE *W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
M

8. DATE OF BIRTH *11/21/1893*

9. AGE (In years last birthday) *56*

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Inspector

10B. KIND OF BUSINESS OR INDUSTRY
Bendix Radio

11. BIRTHPLACE (State or foreign country)
Maryland

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME *John B. Giesey*

14. MOTHER'S MAIDEN NAME *Fannie Habel*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or or unknown) (If yes, give war or dates of service)
No *None*

16. SOCIAL SECURITY NO.
Unknown

17. INFORMANT *Carrie Giesey - 1903 Homewood Ave*

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Myocardial Infarction*
DUE TO

1 3/4 hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Atherosclerotic Cardiovascular Disease*
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2/21/50 10:45 am*, to *2/21/50 10:45 am*, 19 *50*, that I last saw the deceased alive on *2/21*, 19 *50*, and that death occurred at *10:45 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE *David Teaser*

M. D.

23B. ADDRESS *4 E. Chase St.*

23C. DATE SIGNED *2/21/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE *2/25/1950*

24C. NAME OF CEMETERY OR CREMATORY *Louden Park Cemetery*

24D. LOCATION (City, town, or county) (State)
Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE *Washington Williams*

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

Lilly & Zeller Inc. Baltimore, Md.

VS 150

49635

937

MEDICAL CERTIFICATION

87. Letter

STATE OF CALIFORNIA

1949
1893

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Otto Frederick Thierfelder

2. DATE
OF
DEATH

2- 21- 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION Baltimore City Hospitals
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3911 Fait Ave. Z 24

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

5/21/1882

9. AGE (In years
last birthday)

67

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

MECHANIST

10B. KIND OF BUSINESS OR
INDUSTRY

BOTTLING WKS

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO Cranio Cerebral Injury

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Lenear Fracture left Parieto- Frontal

DUE TO Subarachnoid Hemorrhage
Intra Cerebral Hemorrhage

(C) Cerebral Contusion.

CERTIFICATION APPROVED BY

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Home of Daughter-in-law

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

3911 Fait Ave. Baltimore 24

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Feb. 10-1950.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slipped and fell to the floor
Fell At Home Of Daughter- in-law.22. I hereby certify that I attended the deceased from 2-10- , 1950, to 2- 21- , 1950, that I last saw the
deceased alive on 2- 21- 1950 and that death occurred at 6.45AM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

B.C.H. 4940 Eastern Ave.

2- 21- 1950.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL 2/24/50 OAK LAWN BALTO. CO. MD.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

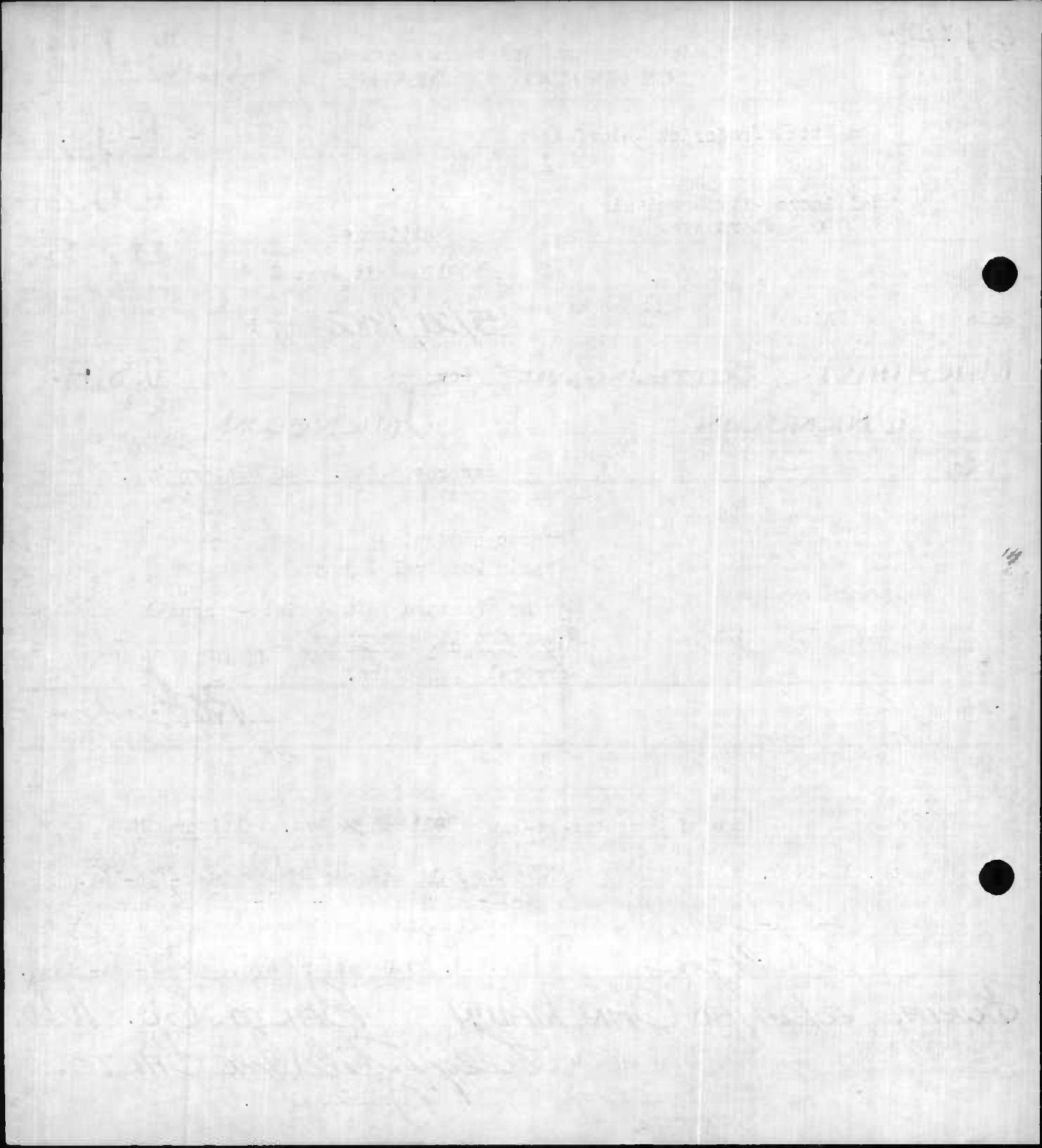
Funeral Home of William J. Kelly & Sons, Inc. BALTO.

VS 150

To Be Approved By The Chief Medical Examiner.

326X0

186a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

443 50 1573
Registered No.

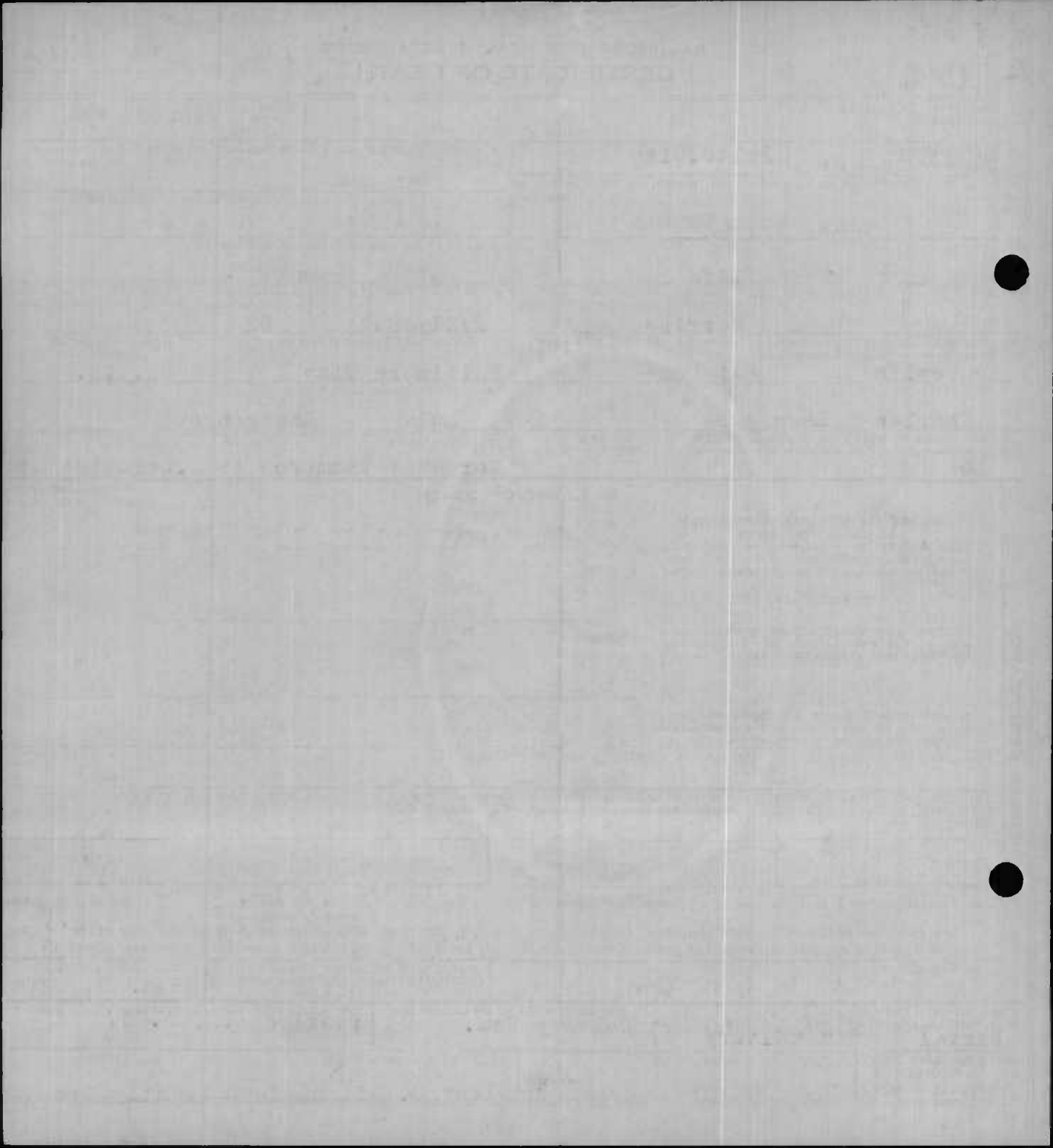
BIRTH NO. 1573

1. NAME OF DECEASED (Type or Print) SARAH ADAMS			2. DATE OF DEATH Feb. 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 3-01		
Length of stay in Baltimore Life Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1420 E. Lombard St.		
5. SEX Female	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2/21/1897		9. AGE (In years last birthday) 52 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore City
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles Lawrence		
14. MOTHER'S MAIDEN NAME Lula Lawrence			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Margaret Thompson 39 S. Caroline St		

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive Cardiovascular Disease (A) DUE TO		
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Insp. & Inq.</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>Elroy O. Wilson</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Feb. 21, 1950	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-22/1950		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.		24D. LOCATION (City, town, or county) (State) Brooklyn A.A.Co.Md.	
DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1950		REGISTRAR'S SIGNATURE <i>Elroy O. Wilson</i>		25. FUNERAL DIRECTOR Elroy O. Wilson		ADDRESS 1000 Brantly Ave	



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

443 Registered No. 50 1574

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Ida Jadwiga Dombkowski</i>			2. DATE OF DEATH <i>Feb. 21 - 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2-03</i>		
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>1726 Lancaster St.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. City</i>		
Length of stay in Baltimore <i>49</i> Yrs. <i>Mon.</i> Days <i>None</i>			D. STREET ADDRESS (If rural, give location) <i>1726 Lancaster St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>About 1885</i>	9. AGE (In years last birthday) <i>64 yrs</i>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Packing Co</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Lord Mott</i>		11. BIRTHPLACE (State or foreign country) <i>Poland</i>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <i>Wroblewski</i>		
14. MOTHER'S MAIDEN NAME <i>✓</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i> 16. SOCIAL SECURITY NO. <i>None</i>		
17. INFORMANT <i>Pawel Dombkowski</i>			ADDRESS <i>1726 Lancaster St</i>		

18. I	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Cerebral Apoplexy</i>		<i>acute</i>
ANTECEDENT CAUSES	(B) <i>Ch. arterio-sclerotic Hypertension</i>		<i>?</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) <i>Chronic myocarditis</i>		<i>?</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>January 1948</i> , to <i>Feb. 21, 1950</i> , that I last saw the deceased alive on <i>Feb. 21, 1950</i> , and that death occurred at <i>4:15 p.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Paul J. Fingles</i>	23B. ADDRESS <i>5007 E. Pratt St.</i>	23C. DATE SIGNED <i>2-21-50</i>

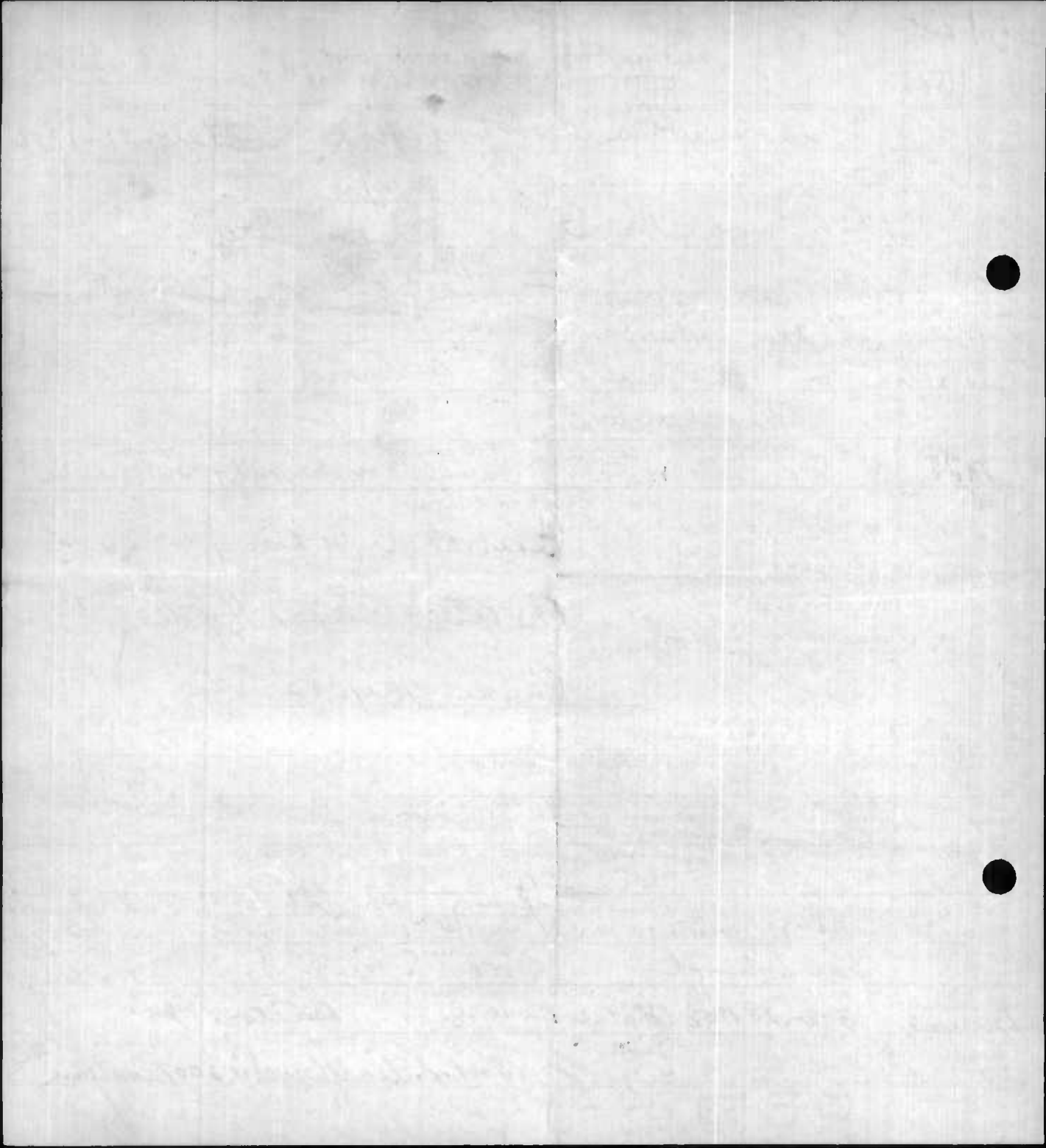
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Feb. 25-1950</i>	24C. NAME OF GEMETERY OR CREMATORY <i>Holy Rosary</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 23 1950</i>	REGISTRAR'S SIGNATURE <i>William S. Fialkowski</i>	25. FUNERAL DIRECTOR <i>Wm. S. Fialkowski</i>	ADDRESS <i>2007 Eastern Ave</i>

VS 150

496XI

1574 93D

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARGARET VANSAS

2. DATE
OF
DEATH

Feb. 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE
Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2000 Clifton Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

15-04

D. STREET ADDRESS (If rural, give location)

2000 Clifton Ave.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Sept. 1, 1867

9. AGE (In years last birthday)

82

10 Under 1 Year
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob Keppler

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

Mrs. Melvin Constantine, Neodemus Rd. Annerstown, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebro-Vascular Accident**
DUE TO

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Arteriosclerosis**
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **2/10**, 19**50**, to **2/20**, 19**50**, that I last saw the deceased alive on **2/20**, 19**50**, and that death occurred at **1:30 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE

Edward D. Hallin

M. D.

23B. ADDRESS

1547 W. North Ave

23C. DATE SIGNED

2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/23/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Tickner & Sons

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER & SONS Balto., Md.

FEB 22 1950

VS 150

500001577

83a

MEDICAL CERTIFICATION

260
50 1576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1576

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RACHEL W. COKER

2. DATE
OF
DEATH

2/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Hospital for Women of Maryland

Length of stay in Baltimore

64

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

15-06

D. STREET ADDRESS (If rural, give location)

3317 Walbrooks

Ok -

5. SEX

7

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

1-17-89

9. AGE (In years last birthday)

61

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Samuel N. Weeks

14. MOTHER'S MAIDEN NAME

Margaret C. Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

1

16. SOCIAL SECURITY NO. none

17. INFORMANT

ADDRESS

Mrs. Jane C. Kirbo 3317 Walbrook Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastases from Carcinoma of uterus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Chronic Cholecystitis

19A. DATE OF OPERATION

2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 12, 1950, to Feb. 21, 1950, that I last saw the deceased alive on Feb. 20, 1950, and that death occurred at 4:20 A. M., from the causes and on the date stated above.

23A. SIGNATURE

John R. Smith, Jr.

M. D.

23B. ADDRESS

Hosp. for Women of Md. Balto. Md.

23C. DATE SIGNED

2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/24/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

FEB 23 1950

REGISTRAR'S SIGNATURE

John R. Smith, Jr.

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.

1500001570

48B

STATE OF TEXAS

COUNTY OF DALLAS

IN SENATE

1901

1

426
50 1577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

E 902.0 50 1577
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

WILLIAM VALENTINE GALLAGHER, Sr. N-820.9

2. DATE
OF
DEATH

2/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balt. Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Mayland Gen. Hosp.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balt. 28-01

D. STREET ADDRESS (If rural, give location)

4214 Penhurst Ave.

Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 7, 1870

9. AGE (In years last birthday)

79

If Under 1 Year Months: Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired merchant

10B. KIND OF BUSINESS OR INDUSTRY

merchant

11. BIRTHPLACE (State or foreign country)

Balt. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Alexander C. Gallagher

14. MOTHER'S MAIDEN NAME

Isabella Foreman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mr. Wm. W. Gallagher, Jr. 3911 Gwynns Falls

ADDRESS Pkwy.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Cerebral Embolus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Fracture of Left Hip

2 weeks

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

Arteriosclerotic Heart Disease

CERTIFICATION APPROVED BY

M. D.

19A. DATE OF OPERATION

2/9/50

19B. MAJOR FINDINGS OF OPERATION

Fracture of Left Hip

CHIEF OR ASS. M.D.

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

kitchen at 4214 Penhurst Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

February 9, 1950 4p.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Slipped and fell to the floor

22. I hereby certify that I attended the deceased from 2/9/1950 to 2/21/1950, that I last saw the deceased alive on 2/21/1950, and that death occurred at 2:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

J. K. Martin M.D.

23B. ADDRESS

Mayland Gen. Hosp.

23C. DATE SIGNED

2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/24/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cem.

24D. LOCATION (City, town, or county)

Pikesville, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

FEB 23 1950

REGISTRAR'S SIGNATURE

William W. Williams, M.D.

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS Balto., Md.

ADDRESS

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ATTEST: _____

DATE: _____

TIME: _____

PLACE: _____

CAUSE: _____

MANNER: _____

AGE: _____

SEX: _____

RACE: _____

EDUCATION: _____

OCCUPATION: _____

RELIGION: _____

ETHNICITY: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

DATE OF BURIAL: _____

PLACE OF BURIAL: _____

DATE OF CREMATION: _____

PLACE OF CREMATION: _____

DATE OF INTERMENT: _____

PLACE OF INTERMENT: _____

DATE OF EXHUMATION: _____

PLACE OF EXHUMATION: _____

DATE OF REINTERMENT: _____

PLACE OF REINTERMENT: _____

DATE OF REINTERMENT: _____

PLACE OF REINTERMENT: _____

534
50 1578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420° 50 1578
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE WILSON SINDALL

2. DATE
OF
DEATH

Feb. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

410 Rock Glen Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

28-04

D. STREET ADDRESS (If rural, give location)

410 Rock Glen Rd.

Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan. 12, 1867

9. AGE (In years last birthday)

83

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)

printer rtd

10B. KIND OF BUSINESS OR INDUSTRY

newspaper

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Samuel Sindall

14. MOTHER'S MAIDEN NAME

Susan Shorey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or noknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Edith N. Sindall

410 Rock Glen Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease about 5 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis unknown

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from July 5, 1946, to Feb 21, 1950, that I last saw the deceased alive on Feb 21, 1950, and that death occurred at 3:15 Pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Leo J. Gaver

M. D.

1 mallow Hill ave, Balto, Md 2/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

2/24/50

Loudon Park Cem.

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

William J. Tickner & Sons

WM. J. TICKNER & SONS

Balto., Md.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Occupation		7. Cause of Death		8. Signature of Physician	
9. Signature of Registrar		10. Date of Registration		11. Place of Registration		12. Remarks	

420
50 1579BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH60
Registered No. 50 1579

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FREDERICK WILLIAM HOHLWEG

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

3329 Piedmont Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE
Md.

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3329 Piedmont Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Apr. 16, 1873

9. AGE (In years
last birthday)

76 yrs.

If Under 1 Year
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Caterer

10B. KIND OF BUSINESS OR
INDUSTRY

Catering

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Valentine Hohlweg

14. MOTHER'S MAIDEN NAME

Augusta Kniern

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Minnie Hohlweg 3329 Piedmont Av

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Acute Coronary Occlusion

15 MIN.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

15 YRS

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Diabetes Mellitus

15 YRS

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Jan 3, 1946, to Feb 22, 1950, that I last saw the deceased alive on Dec 8, 1949, and that death occurred at 5a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2/25/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

WM. J. TICKNER & SONS

Balto., Md.

VS 150

61

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
IN SENATE
JANUARY 1, 1901

REPORT OF THE

COMMISSIONER OF

THE LAND OFFICE

FOR THE YEAR

1900

ALBANY: JAMES B. LEECH, PRINTERS.

1901.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 1580

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

CHARLES FREDERICK MUSSELMAN

2. DATE
OF
DEATH

Feb. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**Shriners Conval. Home
3520 Hilton St.**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

714 Park Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Jan. 3, 1875

9. AGE (In years last birthday)

75

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

clerk

10B. KIND OF BUSINESS OR INDUSTRY

Loan

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Hiram D. Musselman

14. MOTHER'S MAIDEN NAME

Caroline V. Wentz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or ontoown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.
215-05-2484

17. INFORMANT

ADDRESS

Miss Frances C. Musselman 714 Park Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

3 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

10 yrs.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Diabetes Mellitus

3 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from March 6, 1947 to Feb 21, 1950, that I last saw the deceased alive on 2/21, 1950, and that death occurred at 4:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Elber H. Hunselust

M. D.

1801 Eastern Pl

2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/24/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

Wm. J. Tickner & Sons

WM. J. TICKNER & SONS

Balto., Md.

CERTIFICATE OF DEATH

STATE OF NEW YORK

CITY OF NEW YORK

DEPARTMENT OF HEALTH

OFFICE OF THE REGISTRAR

MANHATTAN

BRONX

QUEENS

RICHMOND

ROCKLAND

WESTCHESTER

ALBANY

SCHENECTADY

OTSEGO

ADIRONDACK

COCAINE

HEROIN

MARIJUANA

BARBITURATES

AMPHETAMINE

COCAINE

HEROIN

MARIJUANA

BARBITURATES

AMPHETAMINE

COCAINE

HEROIN

MARIJUANA

BARBITURATES

AMPHETAMINE

COCAINE

HEROIN

MARIJUANA

BARBITURATES

AMPHETAMINE

COCAINE

HEROIN

526
50 1581

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1581

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANKLIN WILLIAM SONGER, JR.

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

3202 Gwynn's Falls Parkway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

3202 Gwynn's Falls Parkway

SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

Jan. 3, 1925

9. AGE (In years
last birthday)

25

10. Under 1 Year Months Days
11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
Student - Law

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Norfolk, Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Franklin Wm. Songer, Sr.

14. MOTHER'S MAIDEN NAME

Emily B. Macon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS Dr.

Mr. Franklin W. Songer 2923 Ellicott

18. 587.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) *Acute Hemorrhagic
Pancreatitis*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Acute alcoholism

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R S Fisher

23B. CHIEF MEDICAL EXAMINER.....☒
ASSISTANT MEDICAL EXAMINER.....☐
M.D. MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED
Feb. 22, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2/25/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Mem. Pk.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

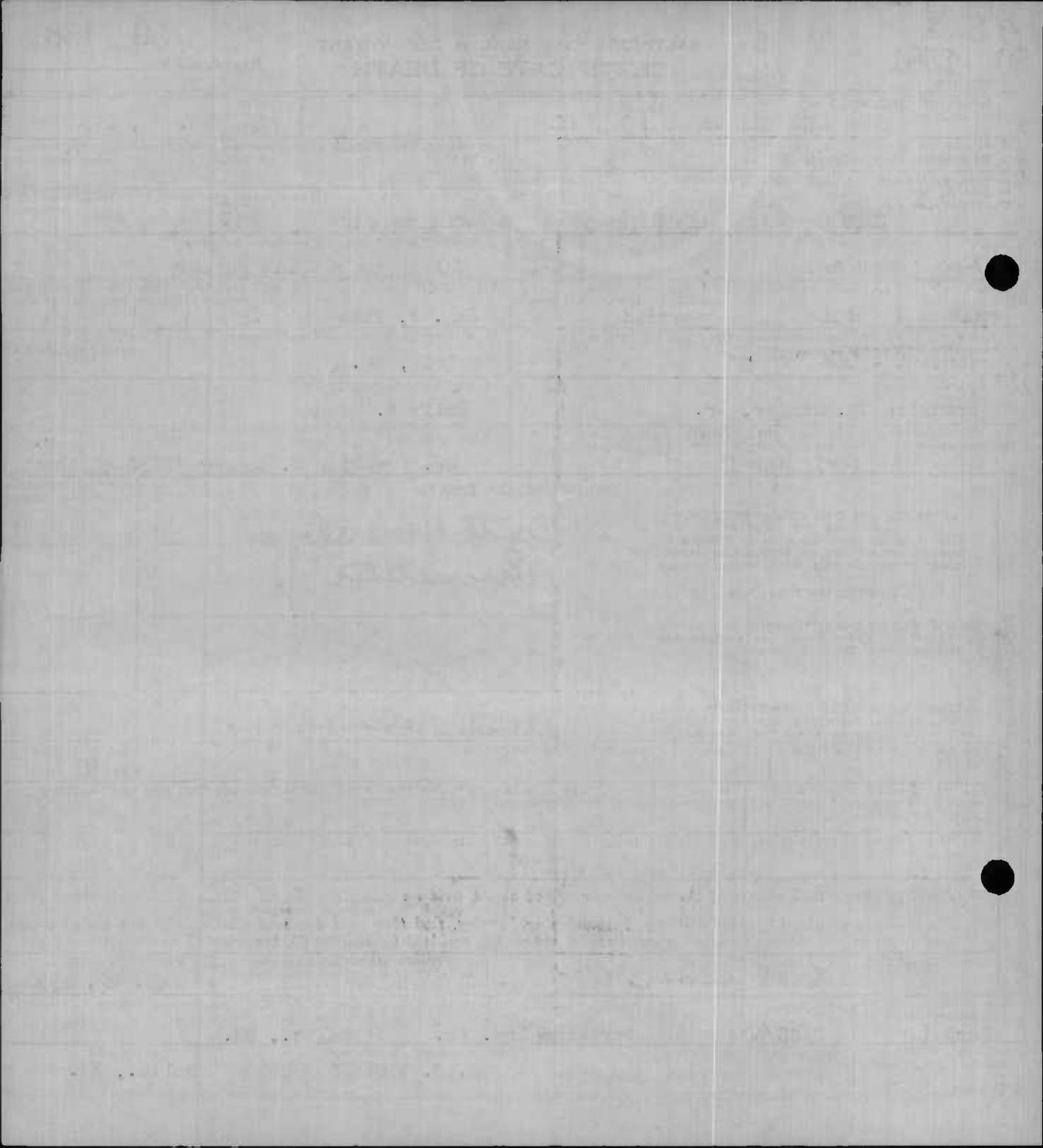
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.



163
50 1582BORN MARCH 15, 1881 - AGE 68 yrs
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 331 Registered No. 50 1582

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRED SHEPPARD

2. DATE

OF

DEATH 2-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

741 W. SARATOGA ST.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 4-02

D. STREET ADDRESS (If rural, give location)

741 W. SARATOGA ST.

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

Yrs.
Mos.
Days

8. DATE OF BIRTH

3-15-1881

9. AGE (In years
last birthday)

66

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

UNEMPLOYED LABORER

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

ACCOMAC, VA.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

JAS. SHEPPARD

14. MOTHER'S MAIDEN NAME

HESTER ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MARY SHEPPARD - 741 SARATOGA ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

26 hrs

ANTECEDENT CAUSES

DISEASES OR CONOITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNOERLYING CONDITION LAST.

(B)

Hypertension

(C)

II
OTHER SIGNIFICANT CONOITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/19 50, to 2/20 50, that I last saw the
deceased alive on 2/20 50, and that death occurred at 11:30 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

2-24-50

MT. AUBURN

BALTIMORE

OATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

Wm. A. Jackson, M.D.

Wm. A. JACKSON - 916 PENNA. AVE

VS 150

98495 150000158483a

90 74

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1583

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOYD GIBSON

2. DATE
OF
DEATH

2-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

662 W. FRANKLIN ST.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE, 1. 17-01

D. STREET ADDRESS (If rural, give location)

662 W. FRANKLIN ST.

5. SEX

MALE

6. COLOR OR RACE

COLORED

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

Yrs.
Mos.
Days

8. DATE OF BIRTH

6-3-82

9. AGE (In years

last birthday)

67

If Under 1 Year
Months: Days

8 19

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

GENERAL

11. BIRTHPLACE (State or foreign country)

WYTHEVILLE, VA.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

FEEBE GIBSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

YES

(If yes, give war or dates of service)
SPAN. AMERICAN

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

ROSA GIBSON - 662 FRANKLIN ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertension

DUE TO

(C)

Diabetes

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/30/41, 1941, to 2/22/50, that I last saw the deceased alive on 2/19/50, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2-25-50

24C. NAME OF CEMETERY OR CREMATORY

BALTO. NATIONAL

24D. LOCATION (City, town, or county)

BALTIMORE

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

Wm. A. JACKSON

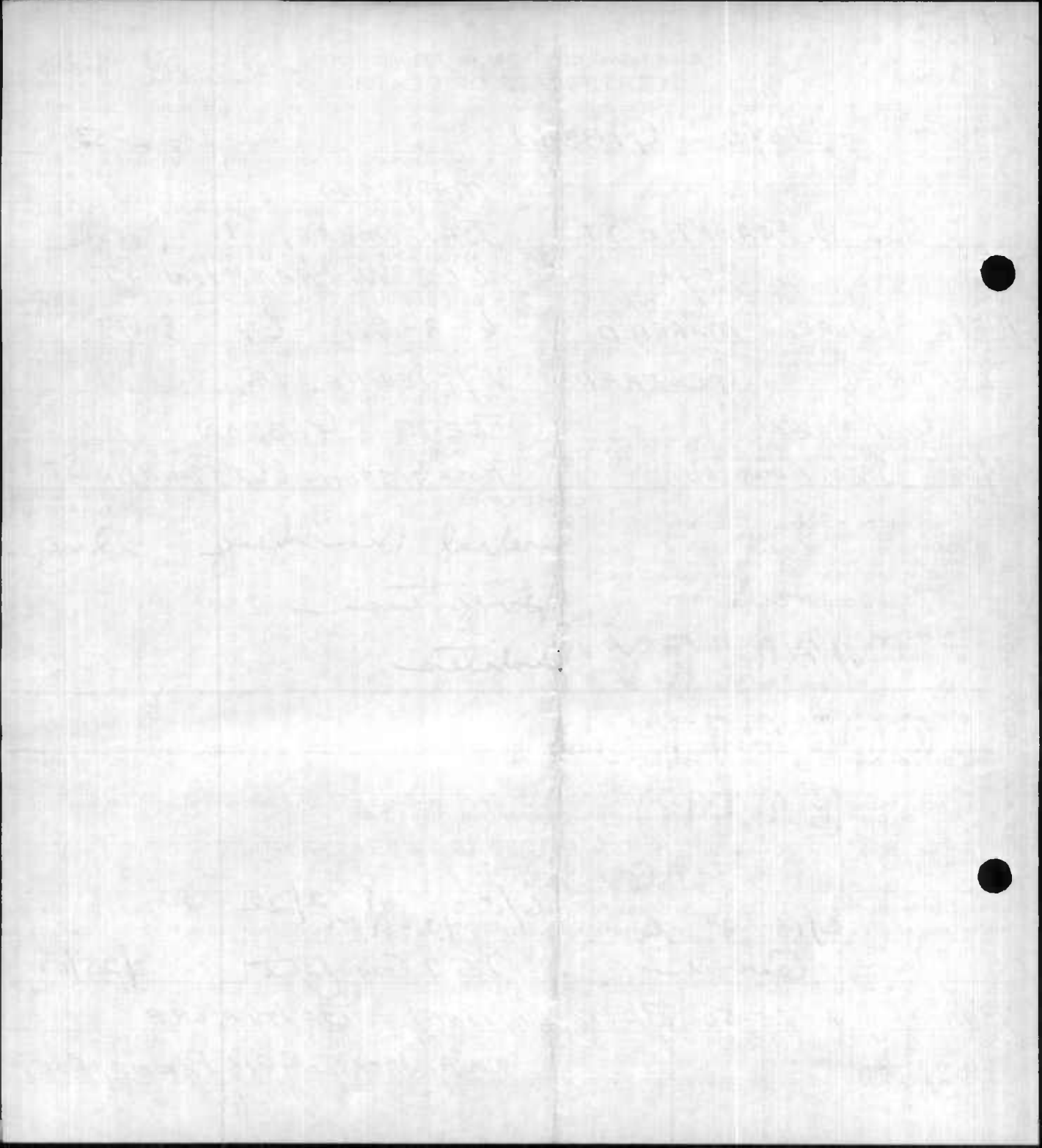
916 PENNA. AVE.

VS 150

98899

1950

61



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 331

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) Lucy Rhone

2. DATE OF DEATH 2-19-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
INSTITUTION 1121 Stricker St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 17 16-02

Length of stay in Baltimore 45 years

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)
1121 N. Stricker St

5. SEX Female

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH Oct 28 1883

9. AGE (In years last birthday) 66 65

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic

10B. KIND OF BUSINESS OR INDUSTRY
own home

11. BIRTHPLACE (State or foreign country)
Middlesex Co. Va

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME
Isiah Townsley

14. MOTHER'S MAIDEN NAME
Harriet Thurston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Ms William Erlaums

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

7 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension + arteriosclerosis

DUE TO

10 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-12-, 1950, to 2-19-, 1950, that I last saw the deceased alive on 2-18-, 1950, and that death occurred at 4 P m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Frank A. Saunders M. D.

1029 N. Stricker St.

2-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE
2/23/50

24C. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial C. Balto. Md

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR
FEB 23 1950

REGISTRAR'S SIGNATURE
William Erlaums

25. FUNERAL DIRECTOR
Rev. H. Nelson

ADDRESS
1303 Chesapeake St

DEPARTMENT OF HEALTH

OFFICE OF THE HEALTH COMMISSIONER

100 NORTH CALVERT STREET, BALTIMORE, MARYLAND

TELEPHONE 2-1234

HOURS: 9:00 A.M. TO 5:00 P.M.

ADMISSION: FREE

APPOINTMENT: BY CARD

EXAMINATION: BY PHYSICIAN

REPORT: BY NURSE

DISCUSSION: BY PHYSICIAN

RECOMMENDATION: BY PHYSICIAN

PRESCRIPTION: BY PHYSICIAN

DIAGNOSIS: BY PHYSICIAN

PROGNOSIS: BY PHYSICIAN

TREATMENT: BY PHYSICIAN

REMARKS: BY PHYSICIAN

SIGNATURE: BY PHYSICIAN

DATE: BY PHYSICIAN

TIME: BY PHYSICIAN

PLACE: BY PHYSICIAN

REASON: BY PHYSICIAN

RESULT: BY PHYSICIAN

REMARKS: BY PHYSICIAN

SIGNATURE: BY PHYSICIAN

DATE: BY PHYSICIAN

TIME: BY PHYSICIAN

PLACE: BY PHYSICIAN

REASON: BY PHYSICIAN

RESULT: BY PHYSICIAN

REMARKS: BY PHYSICIAN

SIGNATURE: BY PHYSICIAN

DATE: BY PHYSICIAN

TIME: BY PHYSICIAN

PLACE: BY PHYSICIAN

REASON: BY PHYSICIAN

RESULT: BY PHYSICIAN

REMARKS: BY PHYSICIAN

SIGNATURE: BY PHYSICIAN

DATE: BY PHYSICIAN

TIME: BY PHYSICIAN

PLACE: BY PHYSICIAN

REASON: BY PHYSICIAN

RESULT: BY PHYSICIAN

REMARKS: BY PHYSICIAN

SIGNATURE: BY PHYSICIAN

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1585
Registered No. 50 1585460
50 1585
BIRTH NO.1. NAME OF DECEASED
(Type or Print)

Joseph R. Schiller

2. DATE
OF
DEATH

Feb 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

205 S. Beechfield Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 28-04

D. STREET ADDRESS (If rural, give location)

205 S. Beechfield Ave

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year

If Under 24 Hours

MALE

White

MARRIED

JAN 28 1883

67

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

MAINTENANCE MAN

Home Building

BALTO MD

13. FATHER'S NAME

BERNARD SCHILLER

14. MOTHER'S MAIDEN NAME

ADA A. WHEELER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-07-2468 ANNIE A. SCHILLER

17. INFORMANT

205 S. Beechfield Ave

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Uremia

5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 1947, 19, to Feb 21, 1950, that I last saw the deceased alive on Feb 21, 1950, and that death occurred at 6:30 m., from the causes and on the date stated above.

23A. SIGNATURE

Edward J. Haeberle M. D.

23B. ADDRESS

1847 W. North

23C. DATE SIGNED

2/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

2/24/50

London Park

BALTO MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 23 1950

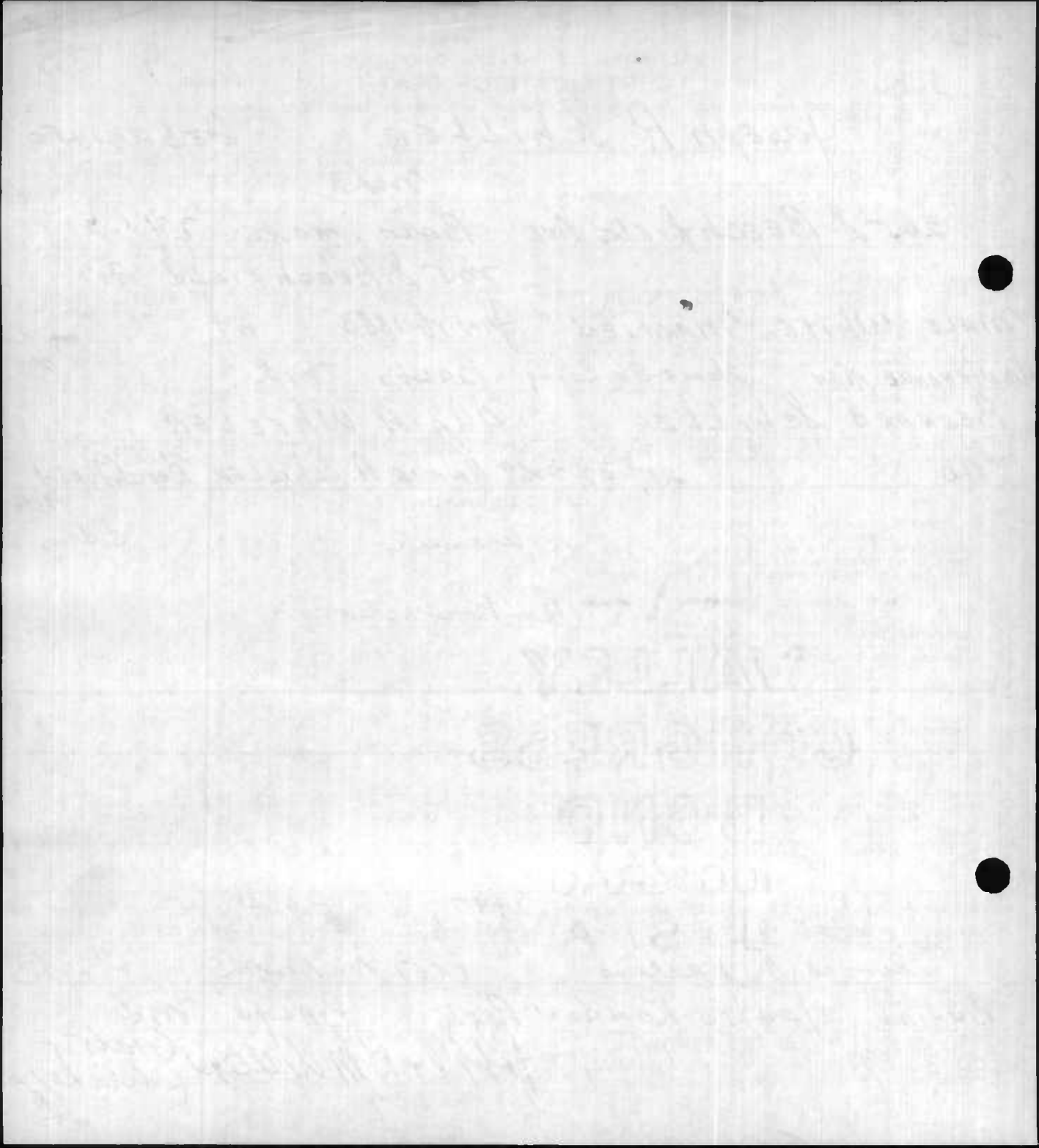
Wilmington, Delaware J. H. C. + B. M. Walter

VS 150

33681

1587 97

Sh



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

50

1586

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE

H.

MUELLER

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1125 W. Franklin St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1125 W. Franklin St.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 26, 1890

9. AGE (In years last birthday)

59

If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Baker

10B. KIND OF BUSINESS OR INDUSTRY

Baker Shop

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Paul Mueller

14. MOTHER'S MAIDEN NAME

Mimmie Schlottawer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

217-07-7890

17. INFORMANT

ADDRESS

Ethel P. Mueller 1125 W. Franklin St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DOE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DOE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒

23C. DATE SIGNED Feb. 23, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

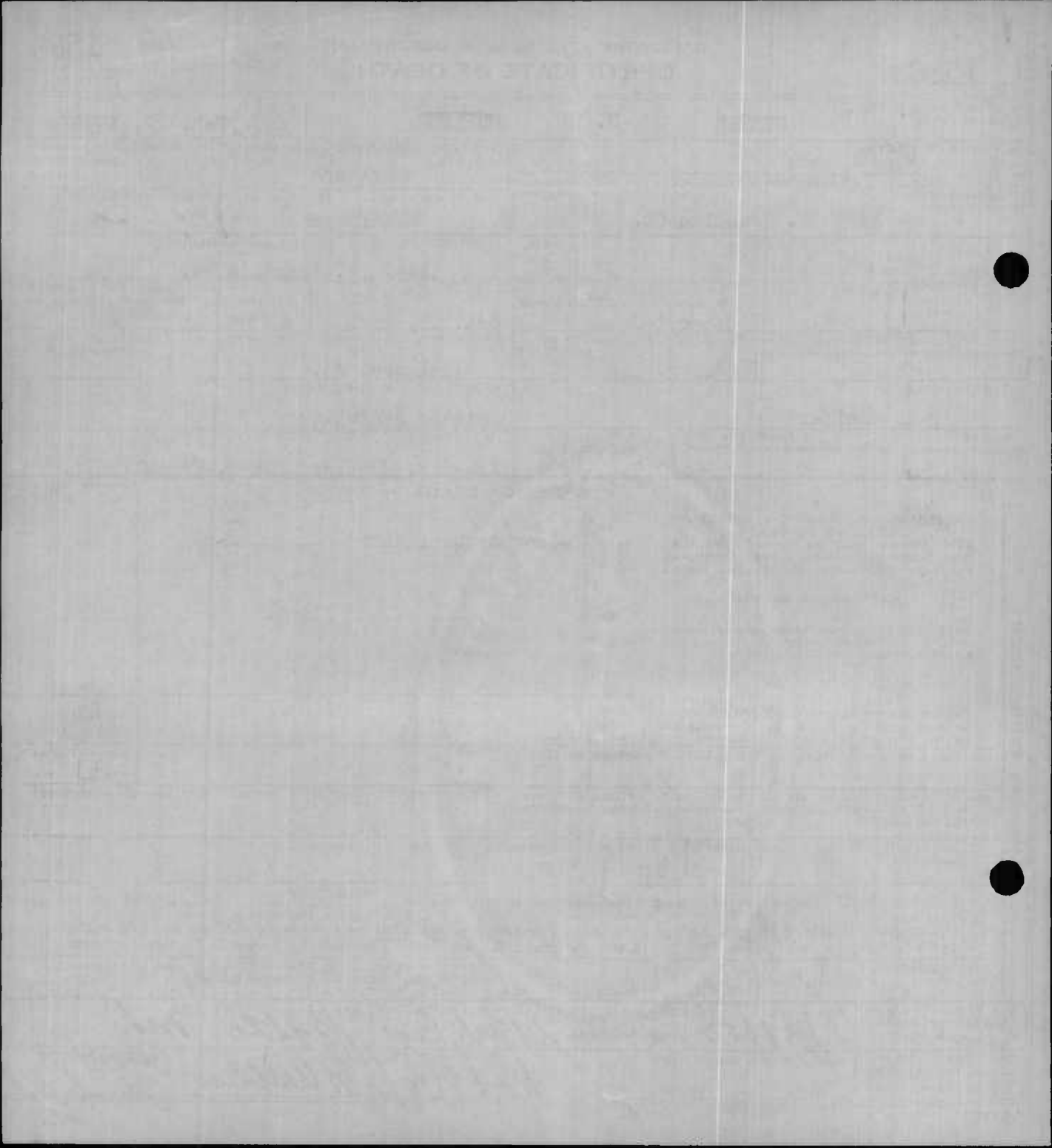
25. FUNERAL DIRECTOR

ADDRESS

VS 151

300XV

94a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 1587

1. NAME OF DECEASED
(Type or Print)

Marie L. Svec

2. DATE
OF
DEATH

Feb 20 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore Md*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

1-01

D. STREET ADDRESS (If rural, give location)

2819 Hudson St

B. FULL NAME OF (If not in hospital or institution, give street address or location)

2819 Hudson St

Length of stay in Baltimore

53 yrs

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Sept 22 1896

9. AGE (In years: last birthday)

53

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry L. Betzold

14. MOTHER'S MAIDEN NAME

Addie Agnes Hook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Joseph L. Svec 2819 Hudson St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

2-19-50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Chr. Myocard. L.S.

1/1948

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Oct 20 1949* to *Feb 20 1950*, that I last saw the deceased alive on *Feb 20 1950* and that death occurred at *7:30* m., from the causes and on the date stated above.

23A. SIGNATURE

William J. Branner, Jr.

23B. ADDRESS

8016 Kenwood Rd

23C. DATE SIGNED

2/22/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Feb 24 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county) (State)

Belair Road Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

John J. Duda Inc 2829 Hudson St

VALLEY
CONDENSED
100/100

5-460 1588

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1588

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Johanna M. Seiler

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

902 Walnut Ave.

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

28-04

D. STREET ADDRESS (If rural, give location)

902 Walnut Ave.

Length of stay in Baltimore

SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 21/75

9. AGE (In years
last birthday)

74

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

H.W.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Koblitz

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Albert Seiler, 902 Walnut Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Disease

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Wm. H. Kammer, Jr.

M.D.

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED

Feb. 22, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Feb. 25/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Pk. 3801 Frederick Rd. Baltimore, 29, M.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. H. Kammer, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Harry T. Lichte 4101 Edmondson Ave.

FEB 23 1950

94a

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

OFFICE OF THE CHIEF, BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

January 1, 1914

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,
Very truly yours,
J. H. R. [Signature]

Chief, Bureau of Plant Industry

Enclosed for you are two copies of a report of the

Commissioner of the General Land Office, dated January 1, 1914,

relative to the proposed establishment of a new

national monument in the State of California.

I am, Sir, very respectfully,
Very truly yours,
J. H. R. [Signature]

Chief, Bureau of Plant Industry

Enclosed for you are two copies of a report of the

Commissioner of the General Land Office, dated January 1, 1914,

relative to the proposed establishment of a new

national monument in the State of California.

I am, Sir, very respectfully,
Very truly yours,
J. H. R. [Signature]

Chief, Bureau of Plant Industry

Enclosed for you are two copies of a report of the

Commissioner of the General Land Office, dated January 1, 1914,

relative to the proposed establishment of a new

national monument in the State of California.

I am, Sir, very respectfully,
Very truly yours,
J. H. R. [Signature]

Chief, Bureau of Plant Industry

Enclosed for you are two copies of a report of the

Commissioner of the General Land Office, dated January 1, 1914,

relative to the proposed establishment of a new

national monument in the State of California.

D-100

50 1589

50 1589

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)Sarah R. Duff 4th2. DATE
OF
DEATH

2/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Baltimore

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore # 23

D. STREET ADDRESS (If rural, give location)

5 Stanley Drive

Length of stay in Baltimore

85 Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

4-29-64

9. AGE (In years,
last birthday)

85

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

ALEXANDER HIGDON

14. MOTHER'S MAIDEN NAME

ANN ELIZA ALLISON

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MR. EDWARD A. SMITH - Above

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Posterior myocardial infarction

3 weeks

DUE TO 3 decompensation

(B) Arteriosclerotic heart
disease

unknown

DUE TO

(C) Hypertensive cardiovascular disease

unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-29-1950 to 2-22-1950 that I last saw the
deceased alive on 2/21-1950, and that death occurred at 1:38 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louisa Cardwell

23B. ADDRESS

Maryland Graduate

23C. DATE SIGNED

2/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Feb 24 50

24C. NAME OF CEMETERY OR CREMATORY

Mt Olivet Cemetery

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Marguerite Louisa Cardwell

25. FUNERAL DIRECTOR

ADDRESS

Marion C. Syfer, 1000 W. Northton

FEB 23 1950

VS 150

MEDICAL CERTIFICATION

50 1589

937

Ma-1685

MA-1685

MA-1685

MA-1685

MA-1685

MA-1685

MA-1685

MA-1685

MA-1685

MA-1685

MA-1685

528 1590

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1590
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mrs. Ella Pauline SCHWINK

2. DATE
OF
DEATH

Feb 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore City

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION1511 E. Lanvale St
Baltimore, Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 8-06

D. STREET ADDRESS (If rural, give location)

1511 E. Lanvale St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed.

8. DATE OF BIRTH

9. AGE (In years last birthday)

62 years

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

THOMA SEVICK

14. MOTHER'S MAIDEN NAME

Amelia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Doris Krick, 1106 E Biddle, Baltimore

18. 592. X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

4 months

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Probably due to chronic nephritis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 19, 1950, to Feb 21, 1950, that I last saw the deceased alive on Feb 19, 1950, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Charles E. Shaw M.D. 1837 Northern Pkwy 12 Feb 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Feb 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county) (State)

E. North Ave Ext

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Geo. S. Legock, 1703 N. Patterson Park Ave

FEB 23 1950

1312

MEDICAL CERTIFICATION

See Document File 50-1596

4-19-50

ES

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

THOMAS J. DURKIN

2. DATE OF DEATH

2.21.1950

3. PLACE OF DEATH:

A. **Baltimore City, Maryland 2724 N. Charles St.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Doctors Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

24-02

D. STREET ADDRESS (If rural, give location)

623 E. Clement St.

Length of stay in Baltimore

About 45 yrs.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

November 9, 1880

9. AGE (In years last birthday)

69

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sugar Sampler

10B. KIND OF BUSINESS OR INDUSTRY

Amer. Sug. Ref. Co.

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Durkin

14. MOTHER'S MAIDEN NAME

Mary Mooney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
212-09-5848

17. INFORMANT

ADDRESS

Julia J. Durkin 623 E. Clement St.

CAUSE OF DEATH

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) _____

Pneumonia - (Broncho)

3 wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) _____

Cardiac Decompensation

1 month.

(C) _____

Cirrhosis of liver.

3 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **Feb 4, 1950**, to **Feb 21, 1950**, that I last saw the deceased alive on **Feb 21, 1950**, and that death occurred at **6:50 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE

Louis J. Gans

23B. ADDRESS

2730 N. Charles St.

23C. DATE SIGNED

2/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-25-50.

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross Cemetery

24D. LOCATION (City, town, or county)

Anne Arundel Co., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

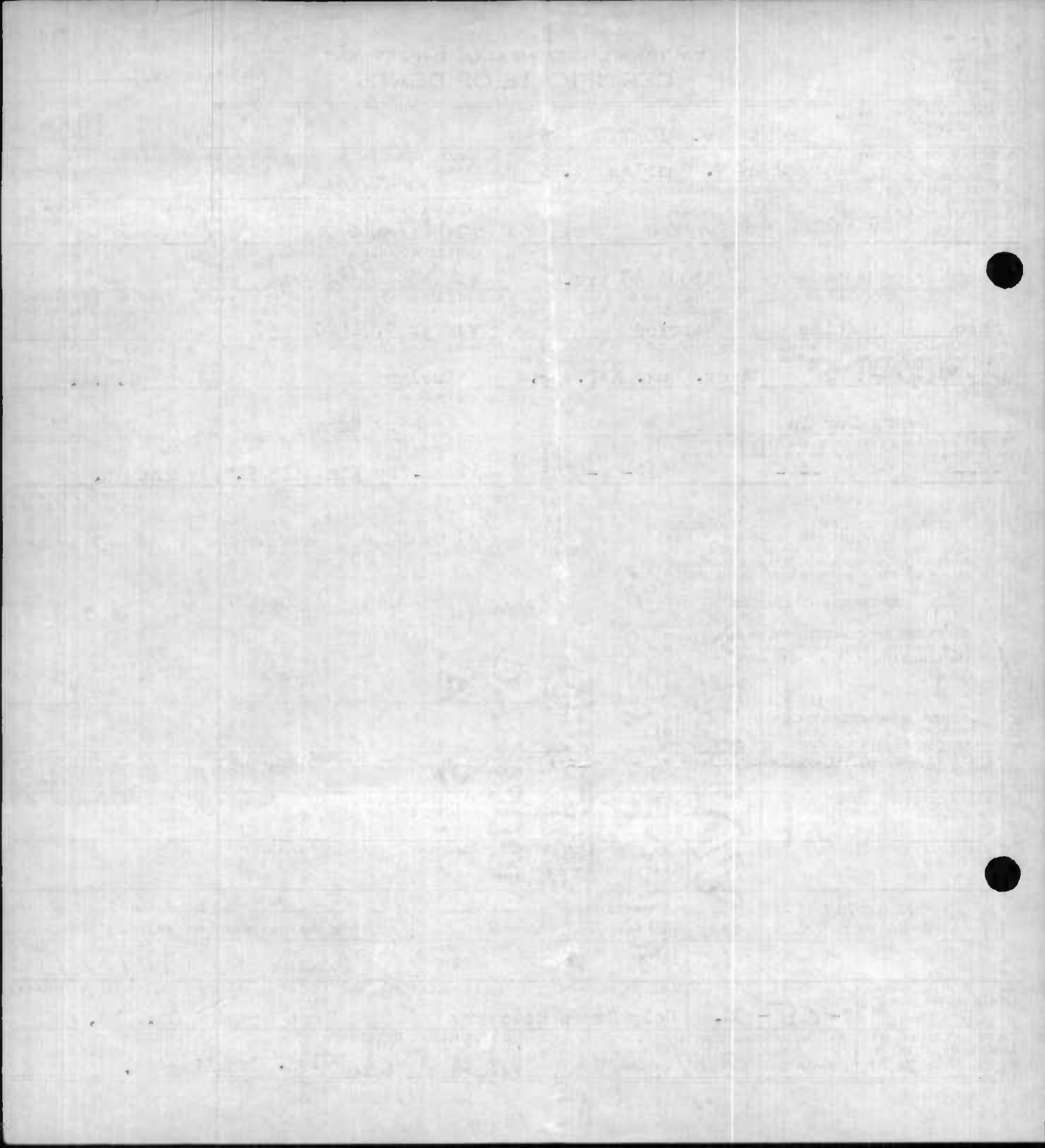
William Williams

25. FUNERAL DIRECTOR

Charles S. Conkling

ADDRESS

901 S. Conkling St.



426
50 1592ALLGEIER
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170

50 1592

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mary Allgeier</i>			2. DATE OF DEATH <i>Feb. 22/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>722 N. Rose St</i>			4. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission) A. STATE <i>MD</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balt</i> <i>3-02</i>		
Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>1515 Lancaster St.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W.</i>	8. DATE OF BIRTH <i>Balt. Md</i>	9. AGE (In years, last birthday) <i>74</i>	If Under 1 Year Months: Days <i>10 27 2</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>			11. BIRTHPLACE (State or foreign country) <i>Mary. 26/1875</i>		
10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Edward J. Blasky</i>			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mrs. Herbert Arthur M. Roast</i>			ADDRESS <i>722</i>		

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Arteriosclerosis</i> DUE TO	<i>10 Yrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>CHRONIC NCPH</i> DUE TO	<i>2 Yrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) <i>CARCINOMA PREST</i>	<i>1 Yr.</i>

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *JAN 30*, 1950, to *FEB 22*, 1950, that I last saw the deceased alive on *FEB 22*, 1950, and that death occurred at *5 P. M.*, from the causes and on the date stated above.

23A. SIGNATURE
James F. Karaman MD. M. D.

23B. ADDRESS
3014 Mc Keesville

23C. DATE SIGNED
2-22-50

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Feb. 25/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Schwartz Cem.</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 23 1950</i>	REGISTRAR'S SIGNATURE <i>William M. Williams</i>	25. FUNERAL DIRECTOR <i>Philip Herwig Sons</i>	ADDRESS <i>Orleans</i>

WALLER
CONCRETE

BOND
DOORHAC

U.S.

425
50 1593BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1593

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Margaret

Wilkinson

2. DATE
OF

DEATH Feb. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

634 E. 36th St.

Length of stay in Baltimore

65

Yrs.

Mos.

Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

May 4th. 1876

9. AGE (In years last birthday)

73 74

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Schmidt

14. MOTHER'S MAIDEN NAME

Margaret Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Gertude Loth 341 E. 28th. St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Intracerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

II

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

H. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D.

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Feb. 21, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/ 24/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John A. Moran 3000 E. Balto. St.

VS 151

Correct age is especially important. In physicians, please write the cause of death clearly and legibly.

CERTIFICATE OF DEATH

1911

1911

1911

1911

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1594
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Emma Claire Grafflin			2. DATE OF DEATH 2 - 22 - 50		
3. PLACE OF DEATH: A. Baltimore City, Maryland 1414 McCulloh St.			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY none		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE 00			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02		
length of stay in Baltimore life Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1414 McCulloh St.		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 8/22/59		9. AGE (In years last birthday) 90
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) musician, retired		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME John Clarke Grafflin			14. MOTHER'S MAIDEN NAME Sue Keener		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Edith Brice Grafflin-1414 McCulloh St.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Arterio-Sclerotic Heart Disease		one year
DUE TO		
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Generalized Arterio Sclerosis		2 years
DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No	21B. PLACE OF INJURY (e. g., to or about house, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from August 15, 1948 , to Feb. 22, 1950 , that I last saw the deceased alive on Feb. 22, 1950 , and that death occurred at 1:15 P. m. , from the causes and on the date stated above.				
23A. SIGNATURE Crawford N. Kilpatrick, Jr. M. D.		23B. ADDRESS 6 E. Eager St.		23C. DATE SIGNED 2 - 23 - 50
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 2 - 24 - 50	24C. NAME OF CEMETERY OR CREMATORY Greenmount	24D. LOCATION (City, town, or county) (State) Baltimore, Md.	

DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1950	REGISTRAR'S SIGNATURE Wm. H. Williams, M.D.	25. FUNERAL DIRECTOR ADDRESS John O. Mitchell & Sons, Inc.-1900 Eutaw Pl.
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VS 150

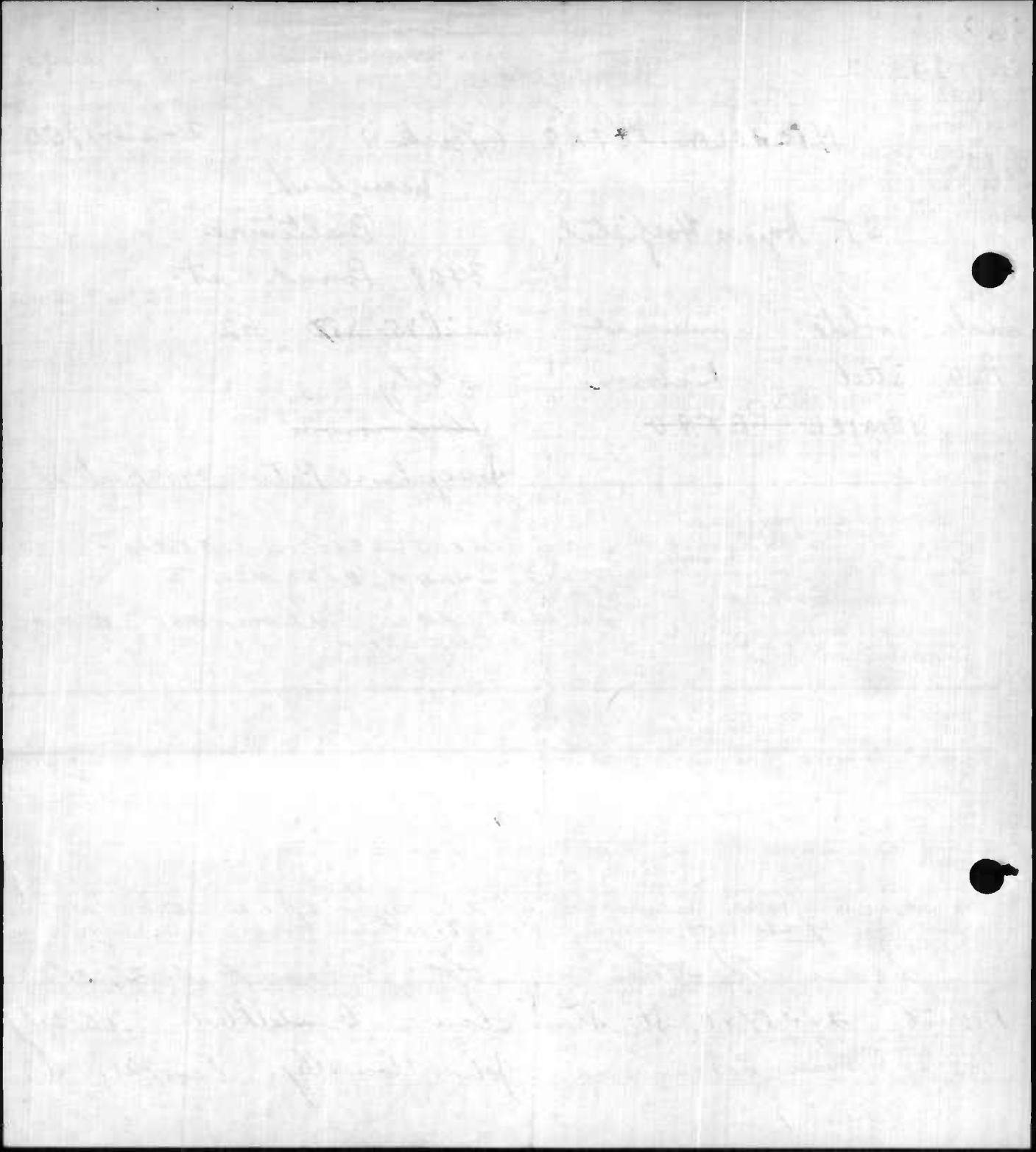
V2890

Wm. H. Williams

John O. Mitchell & Sons, Inc.
937

06 - 45 - 2

860		CERTIFICATE CORRECTED 8-1-52		50 1595 2		50 1595	
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.			
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		NICOLA PETRONGOLO <i>(NICHOLAS PETRO (Nick))</i>		2. DATE OF DEATH		2-22-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore 26-09	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>ST. Agnes Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>3409. Bank St.</i>		Yrs. Mos. Days			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		8. DATE OF BIRTH <i>OCT. 1885</i> <i>March 15-1887</i>	
9. AGE (In years last birthday) <i>64 (62)</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Beth. Steel</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Laborer</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>ISMAELE PETRONGOLO</i> <i>(ISMIEL PETRO)</i>		14. MOTHER'S MAIDEN NAME <i>NUNZIATA DEL CIOTTO</i> <i>(Hunkin)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Josephine Petro</i>		ADDRESS <i>3409 Bank St.</i>	
18. I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>ARTERIOSCLEROTIC CARDIO-</i> DUE TO <i>VASCULAR DISEASE</i>					
ANTECEDENT CAUSES		(B) <i>BILATERAL PULMONARY EDEMA</i> DUE TO <i>AND EFFUSION</i>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>2/21/1950</i> to <i>2/22/1950</i> that I last saw the deceased alive on <i>4/22/1950</i> and that death occurred at <i>7:45</i> m., from the causes and on the date stated above.		23A. SIGNATURE <i>John W. Shaw</i> M. D.		23B. ADDRESS <i>St. Agnes Hosp.</i>		23C. DATE SIGNED <i>3/23/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>2/25/50</i>		<i>St. Stanislaus</i>		<i>Dundalk Ave. Balt. Md.</i>	
OATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>William H. Williams</i>		25. FUNERAL DIRECTOR <i>John J. Connelly</i>		ADDRESS <i>Essex 21, Md.</i>	
FEB 23 1950		VS 150		98F29		937	



632
50 1596BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1596

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bettie Hartig

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

3205 Belmont Ave.,

C. Length of stay in Baltimore

64. Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3205 Belmont Ave.,

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 2, 1868

9. AGE (In years last birthday)

82

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Job Etzel

14. MOTHER'S MAIDEN NAME

Marie Carl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Elvira Schiller 3205 Belmont Av.

CAUSE OF DEATH

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Coronary Sclerosis
DUE TO Arteriosclerosis
and Senility
(B) DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

ml.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1947 to Feb 22, 1950, that I last saw the deceased alive on Feb 22, 1950 and that death occurred at 3:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

M. O.

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Cremation

24B. DATE

2-25-1950

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county)

Baltimore

Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.,

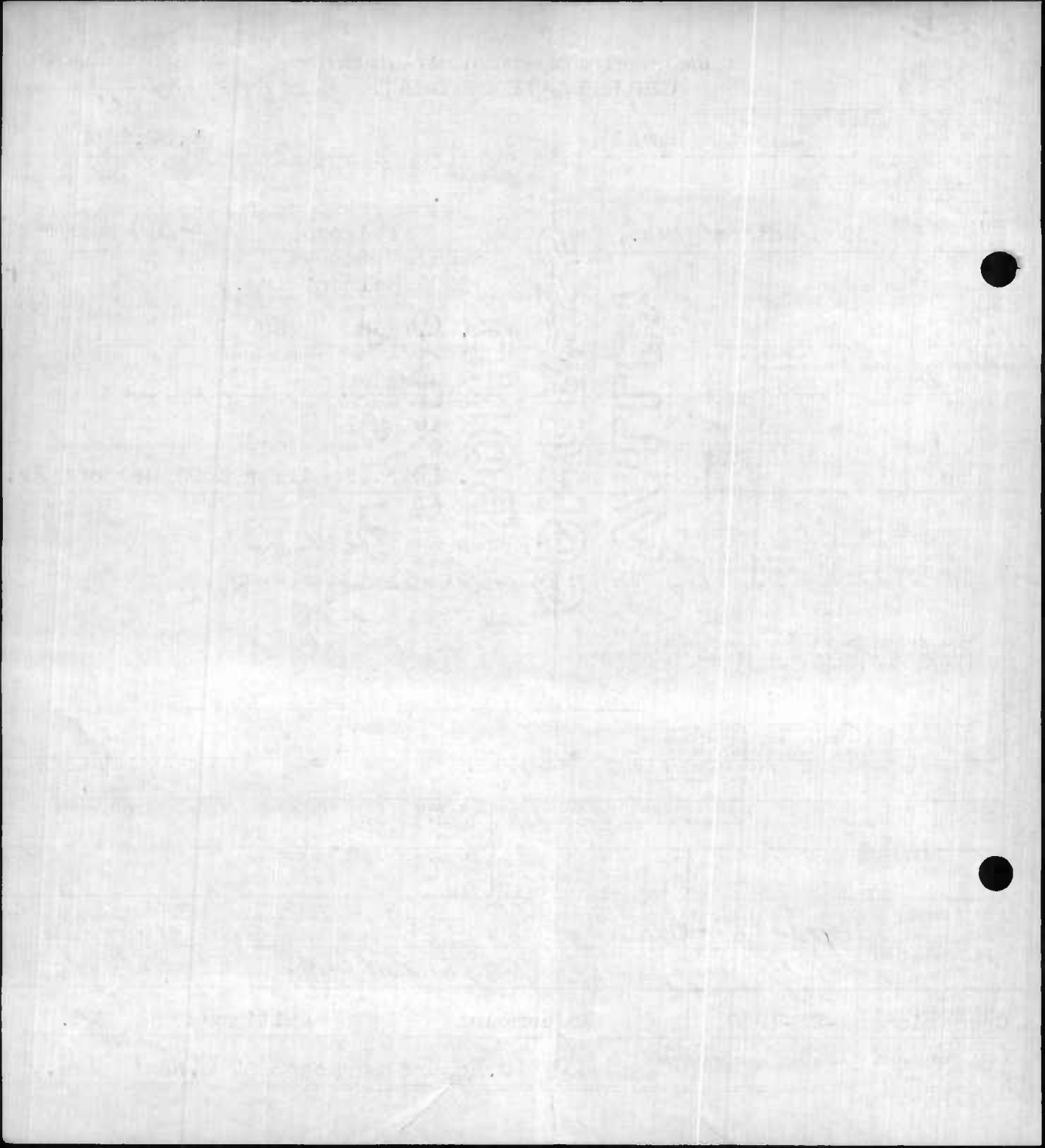
FEB 23 1950

VS 150

MEDICAL CERTIFICATION

1950 00015

94a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 1597

BIRTH NO. 1597

1. NAME OF DECEASED (Type or Print) <u>Joseph A. Mullen</u>		2. DATE OF DEATH <u>February 21, 1950</u>	
3. PLACE OF DEATH A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>11-02</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>	
D. STREET ADDRESS (If rural, give location) <u>4, M. C. A., Franklin and Cathedral Sts.</u>			

5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 21-1884</u>		9. AGE (In years last birthday) <u>66</u>		10. Under 1 Year Months: Days		11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Packing Center Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Emory Mullen</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. Grady</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>068-03-1290</u>				17. INFORMANT <u>Mrs. Fannie Mullen - 7318 Yorktowne</u>					

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Ruptured Abdominal Aortic Aneurysm</u> DUE TO <u>Myocardial Infarction</u> (B) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>8 hrs.</u> <u>1 yr (8)</u>	
--	--	--	--	--	--

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2-21, 1950, to 2-21, 1950, that I last saw the deceased alive on 2-21, 1950, and that death occurred at 6:50 P.M., from the causes and on the date stated above.

23A. SIGNATURE <u>Robert C. Hartmann</u>		23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23C. DATE SIGNED <u>2/22/50</u>	
---	--	---	--	------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>2/24/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Bldg Md</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>23 1950</u>		REGISTRAR'S SIGNATURE <u>Ambridge Williams, Md</u>		25. FUNERAL DIRECTOR <u>Leonard J. Luck - 5305 Bayford Rd</u>		ADDRESS	

21084

96

MEDICAL CERTIFICATION

REPORT OF THE HEALTH OFFICER
CERTIFICATE OF DEATH

15-10-1914
15-10-1914
15-10-1914
15-10-1914
15-10-1914

300
MS--130434
50 1598
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1598

1. NAME OF DECEASED (Type or Print) Grover Scott			2. DATE OF DEATH 2-22-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR location) Baltimore City Hospitals 4940 Eastern Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-01		
D. STREET ADDRESS (If rural, give location) 131 W. Hill St.			E. LENGTH OF stay in Baltimore 26 yrs.		
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 28, 1901		9. AGE (In years last birthday) 49
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY GENL		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Richard Scott (Dec)			14. MOTHER'S MAIDEN NAME Adelaide		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Baltimore City Hospitals Records--4940 Eastern Ave.	

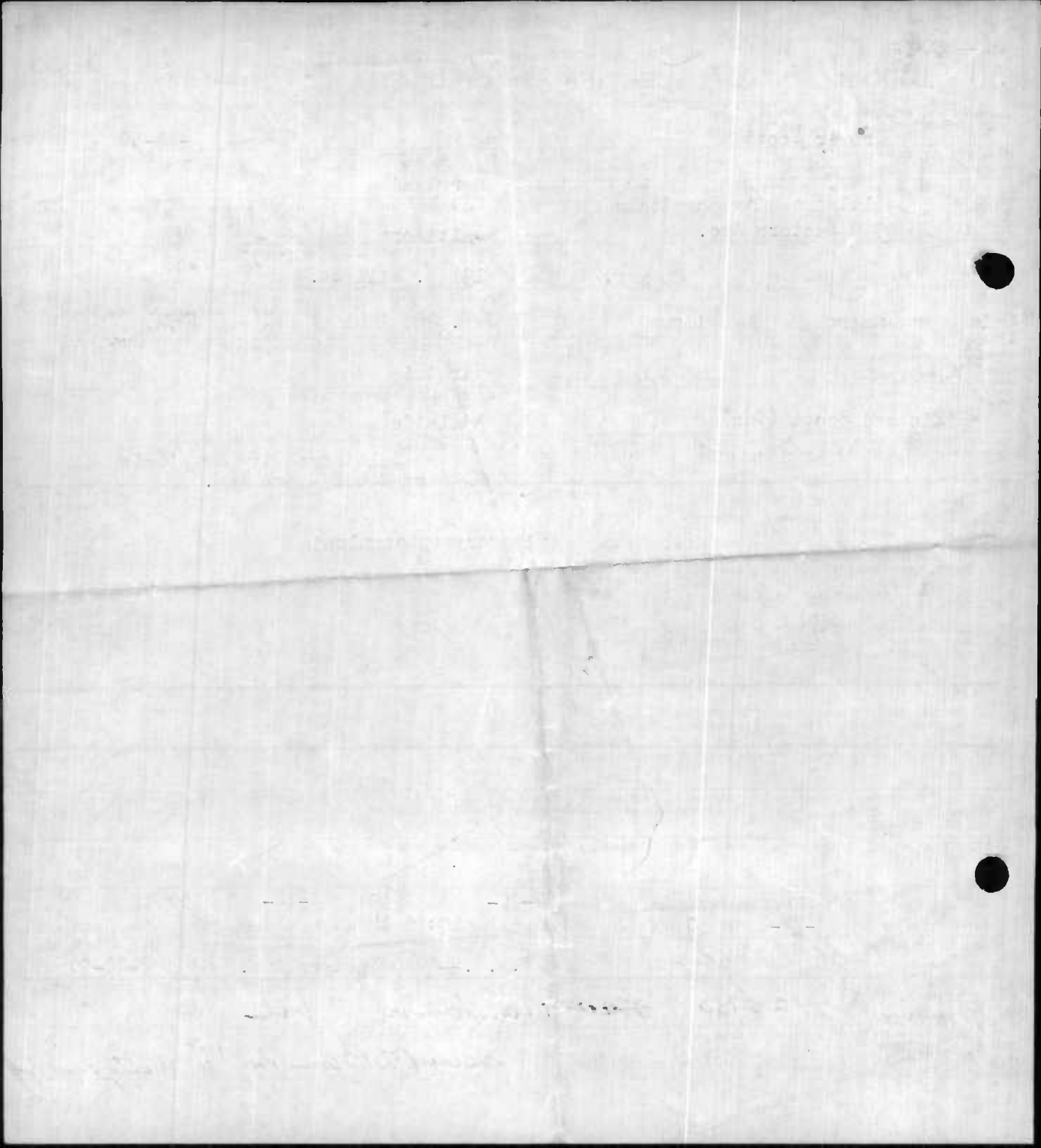
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary tuberculosis (A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-20- , 19 49 , to 2-22- , 19 50 , that I last saw the deceased alive on 2-22- , 19 50 , and that death occurred at 10:10 AM from the causes and on the date stated above.					
23A. SIGNATURE <i>E. B. Oyster</i>		23B. ADDRESS B.C.H.--4940 Eastern Ave.		23C. DATE SIGNED 2-22-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 2/25/50		24C. NAME OF CEMETERY OR CREMATORY Free Frankeluta		24D. LOCATION (City, town, or county) (State) ba	
DATE RECEIVED BY LOCAL REGISTRAR FEB 23 1950		REGISTRAR'S SIGNATURE <i>Thurston Williams</i>		25. FUNERAL DIRECTOR Isaac L. Brown		ADDRESS 168 Montgomery St	

98899

13B



50 1599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anna L. Lvorak

2. DATE
OF
DEATH

Feb. 21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2114 E. Madison St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

917 N. Castle St

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9-22-1874

9. AGE (in years last birthday)

75

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Bohemia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Fridt

14. MOTHER'S MAIDEN NAME

Anna Stepl

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Naclav Lvorak 917 N. Castle St

ADDRESS

18.

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Chr Myocarditis

(C)

INTERVAL BETWEEN
ONSET AND DEATH

Feb 21/50

14
Oct 1-4/50

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

m.

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 20, 1950, to Feb 21, 1950, that I last saw the deceased alive on Feb 21, 1950, and that death occurred at 2:00 m., from the causes and on the date stated above.

23A. SIGNATURE

William F. Rydman, M.D.

23B. ADDRESS

801 E. Kenwood Ave

23C. DATE SIGNED

2/22/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2-25-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR.

REGISTRAR'S SIGNATURE

William F. Rydman, M.D.

25. FUNERAL DIRECTOR

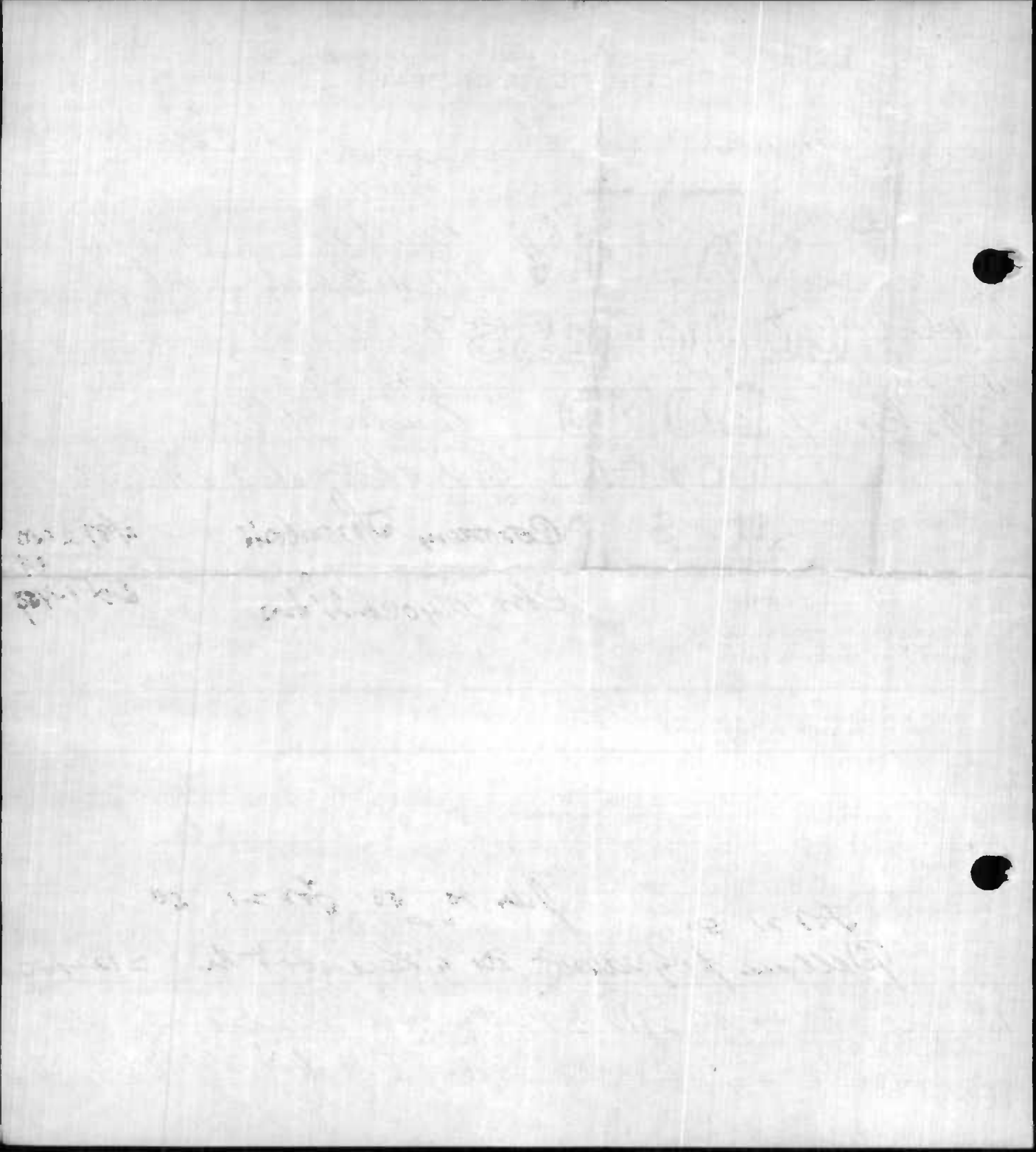
Frank E. Wood, 9004 Chestnut

ADDRESS

FEB 23 1950

937

MEDICAL CERTIFICATION



50 1600

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1600

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

KATIE B. APPLEBAUM

2. DATE
OF
DEATH

February 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

5806 Jonquil Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5806 Jonquil Avenue

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

MARRIED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Oct 7, 1888

9. AGE (In years last birthday)

61

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Jacob J. Galvin

14. MOTHER'S MAIDEN NAME

Leba Feldsher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Sidney Sussman 5808 Jonquil Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Gloma Spinal Cord

13 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

1/30/49

19B. MAJOR FINDINGS OF OPERATION

Improvement in function of spinal cord

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19, to 2/23, 1950, that I last saw the deceased alive on 2/23, 1950, and that death occurred at 1:15 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Nathan Skunk MD

23B. ADDRESS

2320 Euterpe

23C. DATE SIGNED

2/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-24-50

24C. NAME OF CEMETERY OR CREMATORY

Aitz Chaim Cong.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

ADDRESS

Sol Levinson & Eros. 1124-26 W North Avenue

VS 150

FEB 24 1950

FEB 24 1950

FEB 24 1950

FEB 24 1950

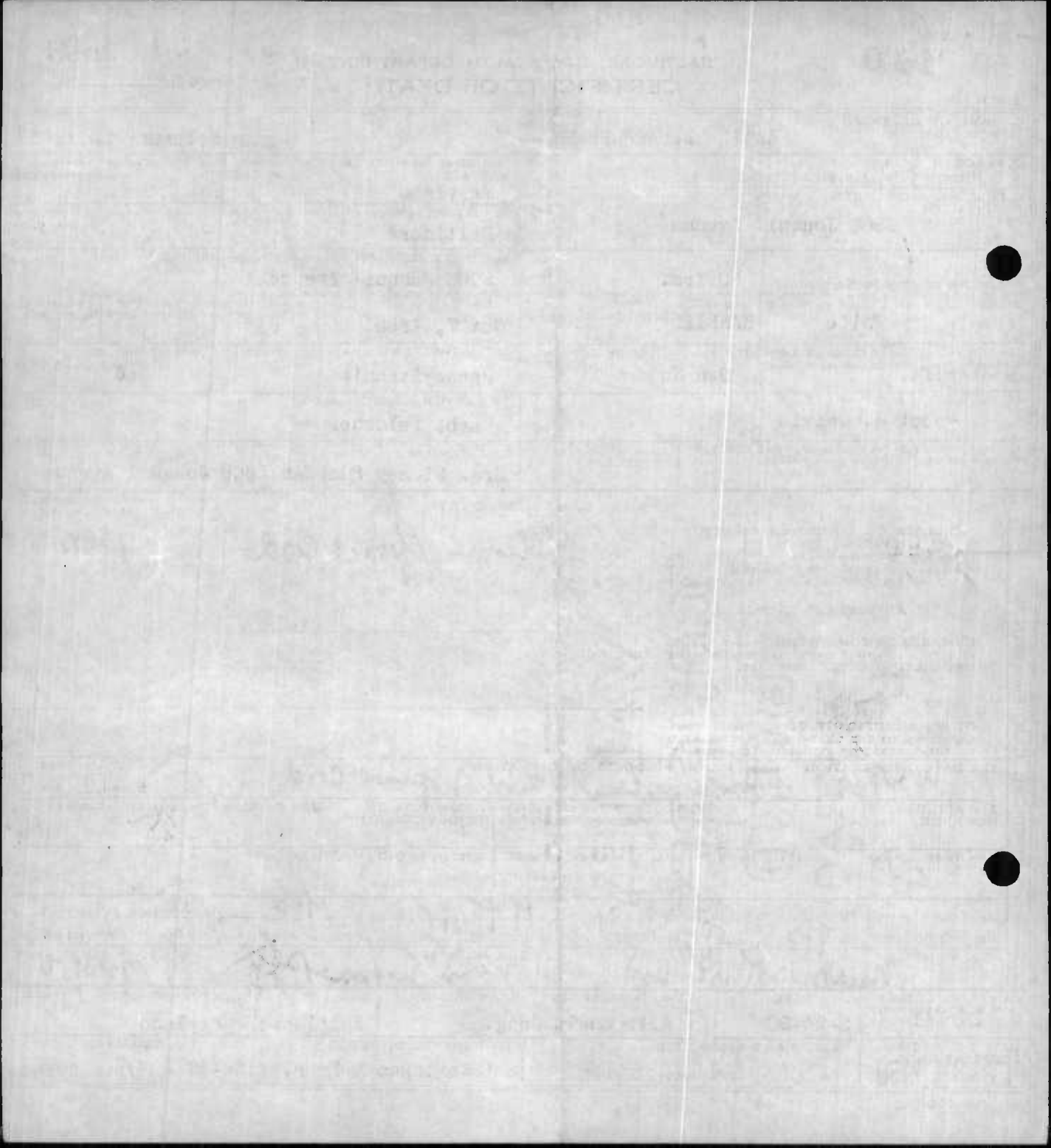
FEB 24 1950

FEB 24 1950

FEB 24 1950

FEB 24 1950

FEB 24 1950



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1601**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Abraham Winters			2. DATE OF DEATH Feb 22, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Marlborough Apts 6 F. Eutaw Place & Wilson St			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-01		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) Marlborough Apts 6 F Eutaw Place & wilson Sts		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 18, 1886		9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restaurant Business			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md
13. FATHER'S NAME Harry Winters			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 217-16-3223		
			17. INFORMANT ADDRESS Agnes Steele Winters Marlborough Apts		

<p>18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p align="center">CAUSE OF DEATH</p> <p>(A) <u>Cerebral hemorrhage</u> DUE TO</p> <p align="center">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>(B) <u>Coronary Disease</u> DUE TO</p> <p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p>(C) <u>Arteriosclerosis</u> <u>Hypertension</u></p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>
--	---

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 1947 to Feb 22, 1950, that I last saw the deceased alive on 2-21, 1950, and that death occurred at 4 A m., from the causes and on the date stated above.

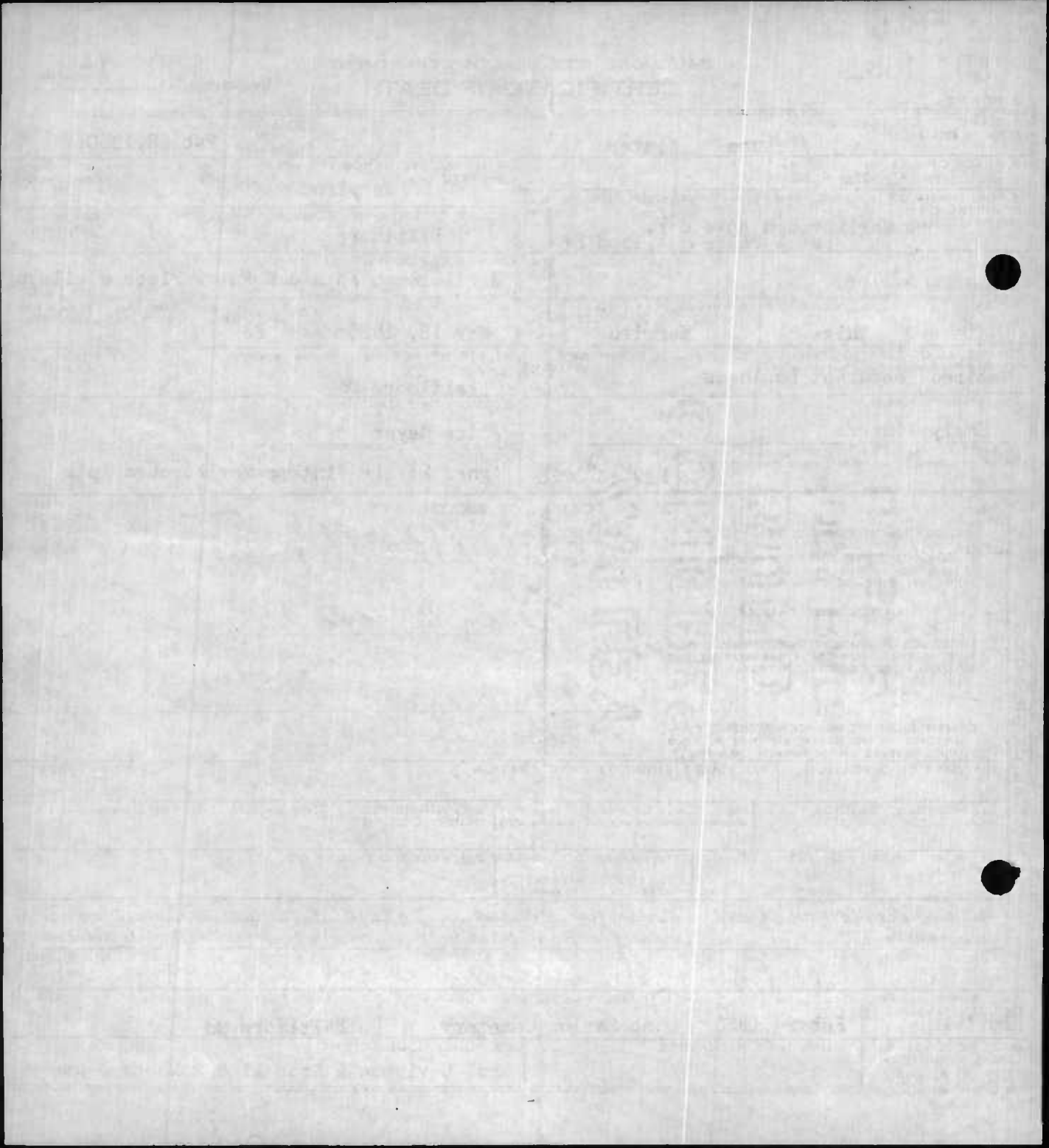
23A. SIGNATURE <u>Dr. Bernard P. ...</u>	23B. ADDRESS <u>Marlborough Apts</u>	23C. DATE SIGNED <u>2/22/50</u>
---	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb 24, 1950	24C. NAME OF CEMETERY OR CREMATORY Oheb Shalom Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore Md
--	----------------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR FEB 24 1950	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros 1126 W North Ave
--	---	---

156 71 149 500001603 94a

MEDICAL CERTIFICATION



50 1602

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1602

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BESSIE CRAFT

2. DATE
OF
DEATH

Feb 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

BALTO

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

West Baltimore General Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2903 Brighton St. 16-07

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

4/7/1879

9. AGE (In years
last birthday)

70

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

13. FATHER'S NAME

Jones Daughman

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Sarah A. Stout

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Chas. L. W. Craft 2903 Brighton St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Myocardial Infarction

approx 10 hrs
estimate
5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

HASCVD.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONOITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)22. TIME (Month) (Day) (Year) (Hour)
OF INJURY

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from 4:22, 1950, to 4:22, 1950, that I last saw the
deceased alive on 2/22, 1950, and that death occurred at 11:41 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Shea

M. D.

23B. ADDRESS

WBPH

23C. DATE SIGNED

2-23-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial

2/25/50

Presbyterian

Gowans

FEB 25 1950

William M. Williams, M.D.

Wm. Cook Inc. 1217 St. Paul St

613 50 1602

93D

THE UNIVERSITY OF CHICAGO PRESS

320
50 1603BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 410

50 1603

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lena E. Barnes Luedecke		2. DATE OF DEATH Feb. 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 117 Parkin Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-03	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 117 Parkin Street	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH About 1869
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (in years last birthday) about 80 If Under 1 Year Months: Days If Under 24 Hours Hours: Min
13. FATHER'S NAME Moses Greenberg		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknowns) no		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Annie ?	
17. INFORMANT Mrs. Ethel Jugo, 1615 Bank Street		ADDRESS	

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Intest. insufficiency*
DUE TO

ANTECEDENT CAUSES

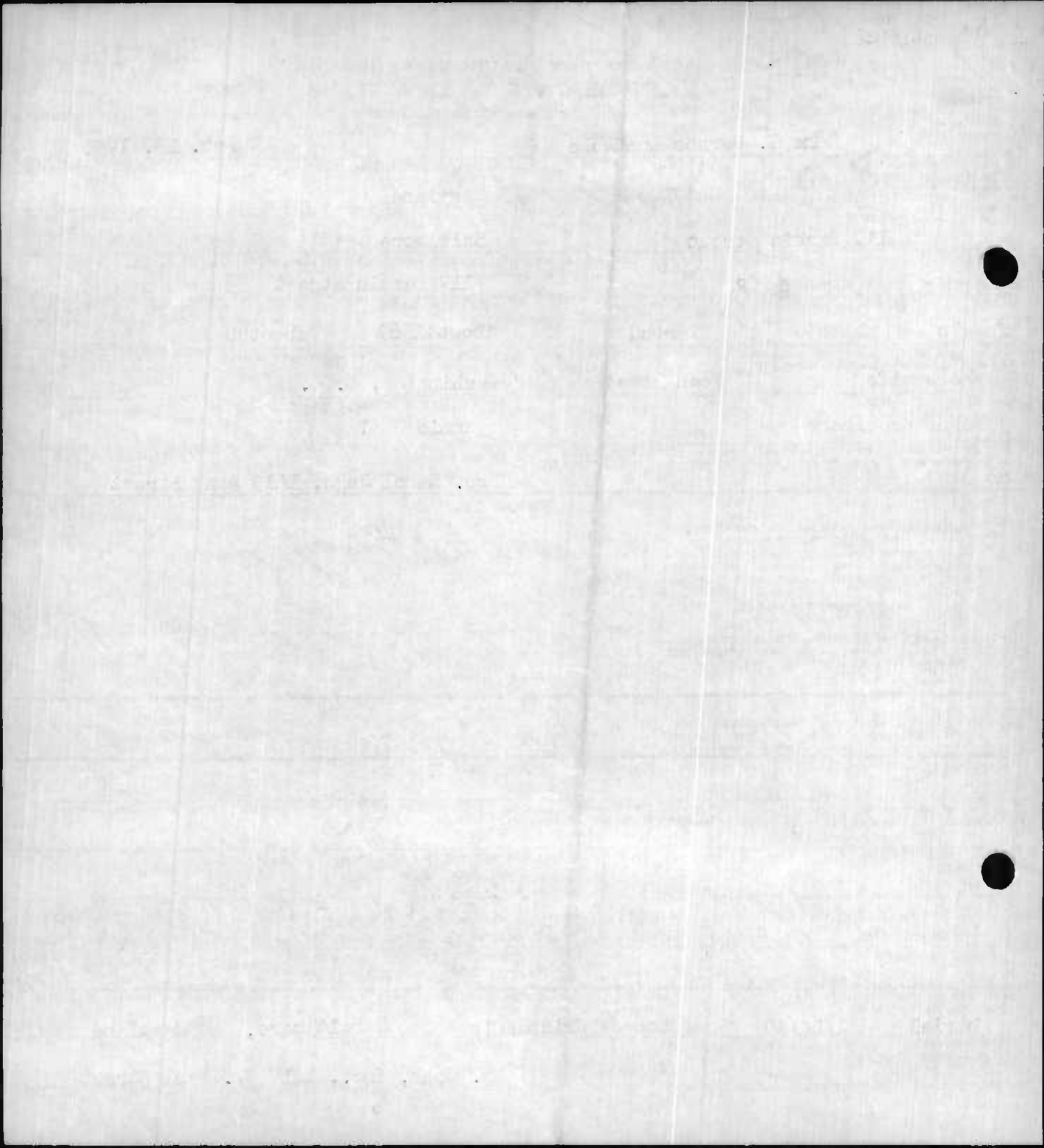
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)
Branchypneumonia

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb 17, 1950</i> to <i>Feb 23, 1950</i> , that I last saw the deceased alive on <i>Feb 22, 1950</i> , and that death occurred at <i>6:30 a.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>William Williams, M.D.</i>		23B. ADDRESS <i>1829 N. Fayette St.</i>		23C. DATE SIGNED <i>Feb 23/1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE 2/24/50		24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship	
DATE RECEIVED BY LOCAL REGISTRAR FEB 24 1950		REGISTRAR'S SIGNATURE <i>William Williams, M.D.</i>		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
VS 150		25. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS	



460
50 1604

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1604
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY L. MILLER

2. DATE
OF

DEATH FEB 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1112 W. FAYETTE ST

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE

MARYLAND.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE 18-02

D. STREET ADDRESS (If rural, give location)
1112 W. FAYETTE ST

C. Length of stay in Baltimore

LIFE

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

SEPT 23, 1876

9. AGE (in years last birthday)

73

10. Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWORK.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

JOSHUA S. MILLER

14. MOTHER'S MAIDEN NAME

LOUISA A. MILLER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

MARIE J. MARTIN - 805 POWERS ST.

18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Mitral Stenosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Congestive Ht Failure

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb 15, 1950, to Feb 22, 1950, that I last saw the deceased alive on Feb 22, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Walter Lisonich

M. D.

1829 W Fayette St

2/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

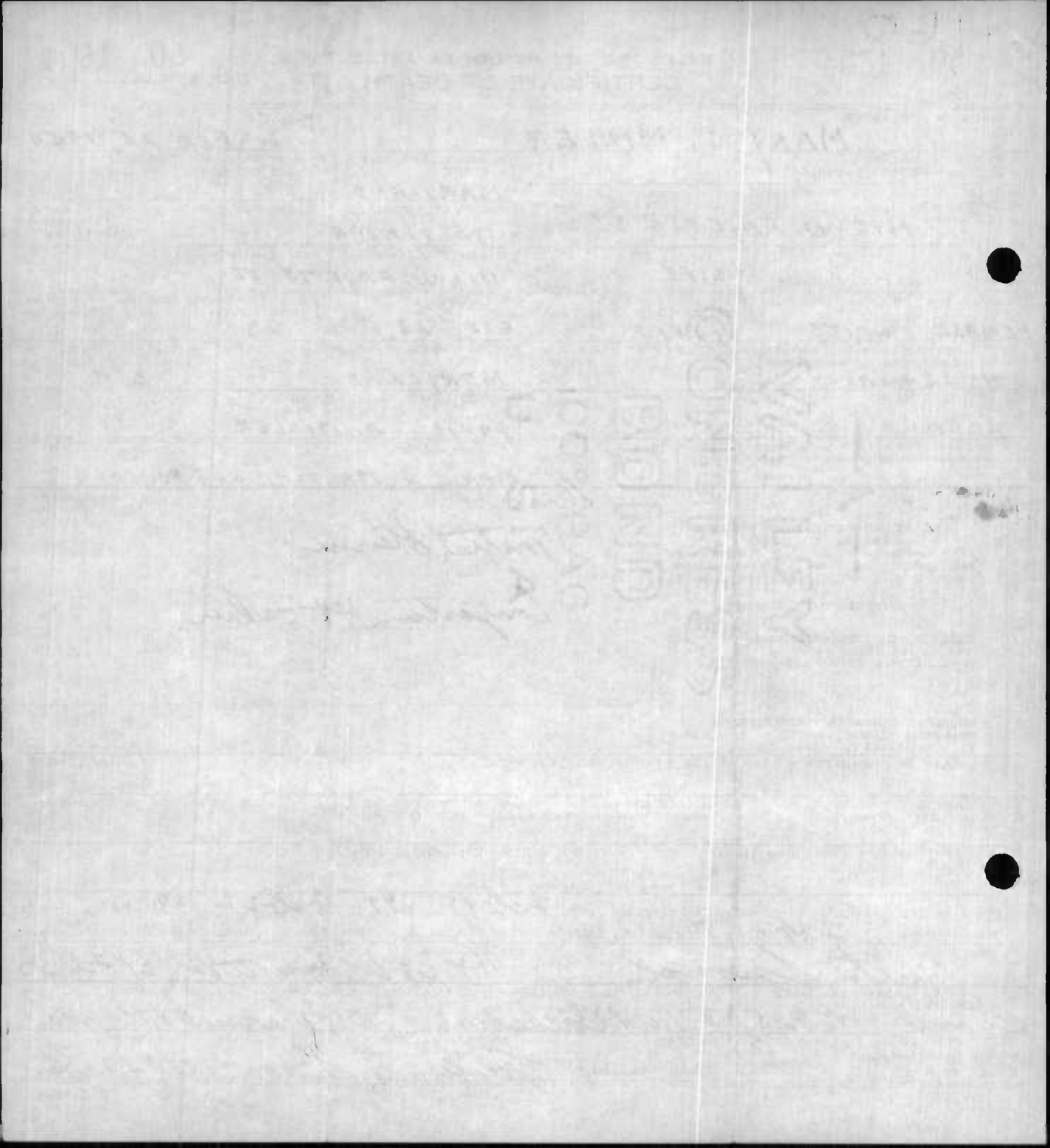
Walter Lisonich, M.D. 1829 W Fayette St

VS 150

77087

9212

MEDICAL CERTIFICATION



50 1605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 1605

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

George H. De Lashmuth

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

1331 Webster

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

Sept 15, 1865

9. AGE (In years
last birthday)

81

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

R.R. Conductor

10B. KIND OF BUSINESS OR
INDUSTRY

B.T.O. R.R.

13. FATHER'S NAME

Andrew De Lashmuth

11. BIRTHPLACE (State or foreign country)

Frederick

12. CITIZEN OF
WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

Phoebe Reich

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

John H. De Lashmuth

ADDRESS

1331 Webster

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Thrombosis one
week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

arteriosclerosis 2 years

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Senility
Chronic Myocarditis 2 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8:00 to 2:27, 1950, that I last saw the
deceased alive on 2/24/1950, and that death occurred at 8:45 P.M. from the causes and on the date stated above.

23A. SIGNATURE

Dane Miller M.D.

23B. ADDRESS

1228 S. Charles St.

23C. DATE SIGNED

2/24/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Feb. 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

Balto

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

A. Howard Evans 1400 S. Charles St.

ADDRESS

VS 150

73247

93D

MEDICAL CERTIFICATION

REPORT OF - ALABAMA DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Duration of illness		8. Name of physician	
9. Name of informant		10. Signature of informant		11. Signature of physician		12. Signature of registrar	
13. Name of registrar		14. Signature of registrar		15. Signature of registrar		16. Signature of registrar	
17. Name of registrar		18. Signature of registrar		19. Signature of registrar		20. Signature of registrar	
21. Name of registrar		22. Signature of registrar		23. Signature of registrar		24. Signature of registrar	
25. Name of registrar		26. Signature of registrar		27. Signature of registrar		28. Signature of registrar	
29. Name of registrar		30. Signature of registrar		31. Signature of registrar		32. Signature of registrar	
33. Name of registrar		34. Signature of registrar		35. Signature of registrar		36. Signature of registrar	
37. Name of registrar		38. Signature of registrar		39. Signature of registrar		40. Signature of registrar	
41. Name of registrar		42. Signature of registrar		43. Signature of registrar		44. Signature of registrar	
45. Name of registrar		46. Signature of registrar		47. Signature of registrar		48. Signature of registrar	
49. Name of registrar		50. Signature of registrar		51. Signature of registrar		52. Signature of registrar	
53. Name of registrar		54. Signature of registrar		55. Signature of registrar		56. Signature of registrar	
57. Name of registrar		58. Signature of registrar		59. Signature of registrar		60. Signature of registrar	
61. Name of registrar		62. Signature of registrar		63. Signature of registrar		64. Signature of registrar	
65. Name of registrar		66. Signature of registrar		67. Signature of registrar		68. Signature of registrar	
69. Name of registrar		70. Signature of registrar		71. Signature of registrar		72. Signature of registrar	
73. Name of registrar		74. Signature of registrar		75. Signature of registrar		76. Signature of registrar	
77. Name of registrar		78. Signature of registrar		79. Signature of registrar		80. Signature of registrar	
81. Name of registrar		82. Signature of registrar		83. Signature of registrar		84. Signature of registrar	
85. Name of registrar		86. Signature of registrar		87. Signature of registrar		88. Signature of registrar	
89. Name of registrar		90. Signature of registrar		91. Signature of registrar		92. Signature of registrar	
93. Name of registrar		94. Signature of registrar		95. Signature of registrar		96. Signature of registrar	
97. Name of registrar		98. Signature of registrar		99. Signature of registrar		100. Signature of registrar	

50 1606

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1606

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEAH DUBINSKY

2. DATE
OF
DEATH

2-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

Levendale

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 15-12

O. STREET ADDRESS (If rural, give location)

3634 Cottage Ave.

C. Length of stay in Baltimore

28

Yrs.
Moe.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years)

Last birthday

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lith

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Marten

14. MOTHER'S MAIDEN NAME

Leba

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Louis Dubinsky 4344 Carrollton Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary thrombosis

1 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

Coronary sclerosis

years

DUE TO

(C)

Diabetes mellitus

years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1, 1949, to 2-23, 1951, that I last saw the deceased alive on 2-23, 1951, and that death occurred at 10 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Henry Nagel

M. D.

23B. ADDRESS

Levendale Home

23C. DATE SIGNED

2-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

2-24-50

Rosedale

Baltimore

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

William M. Williams

Jack K. Keeske 2100 Eastern Pl

34 collages in
collage

WILEY
COPIERS
BOUND

2500 4000

-140
50 1607

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

420' 50 1607
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY APPLE

2. DATE
OF
DEATH

2-22-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

20-01

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

2012 West Fayette St

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2012 West Fayette St

Length of stay in Baltimore

48

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mattie Wells 2012 W Fayette St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)

Coronary Thrombosis

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Auricular Fibrillation

Dec., 1949

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2/22/50, 19, to 2/22/50, 19, that I last saw the deceased alive on Feb. 22, 19 50 and that death occurred at 9:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

William Williams, M.D.

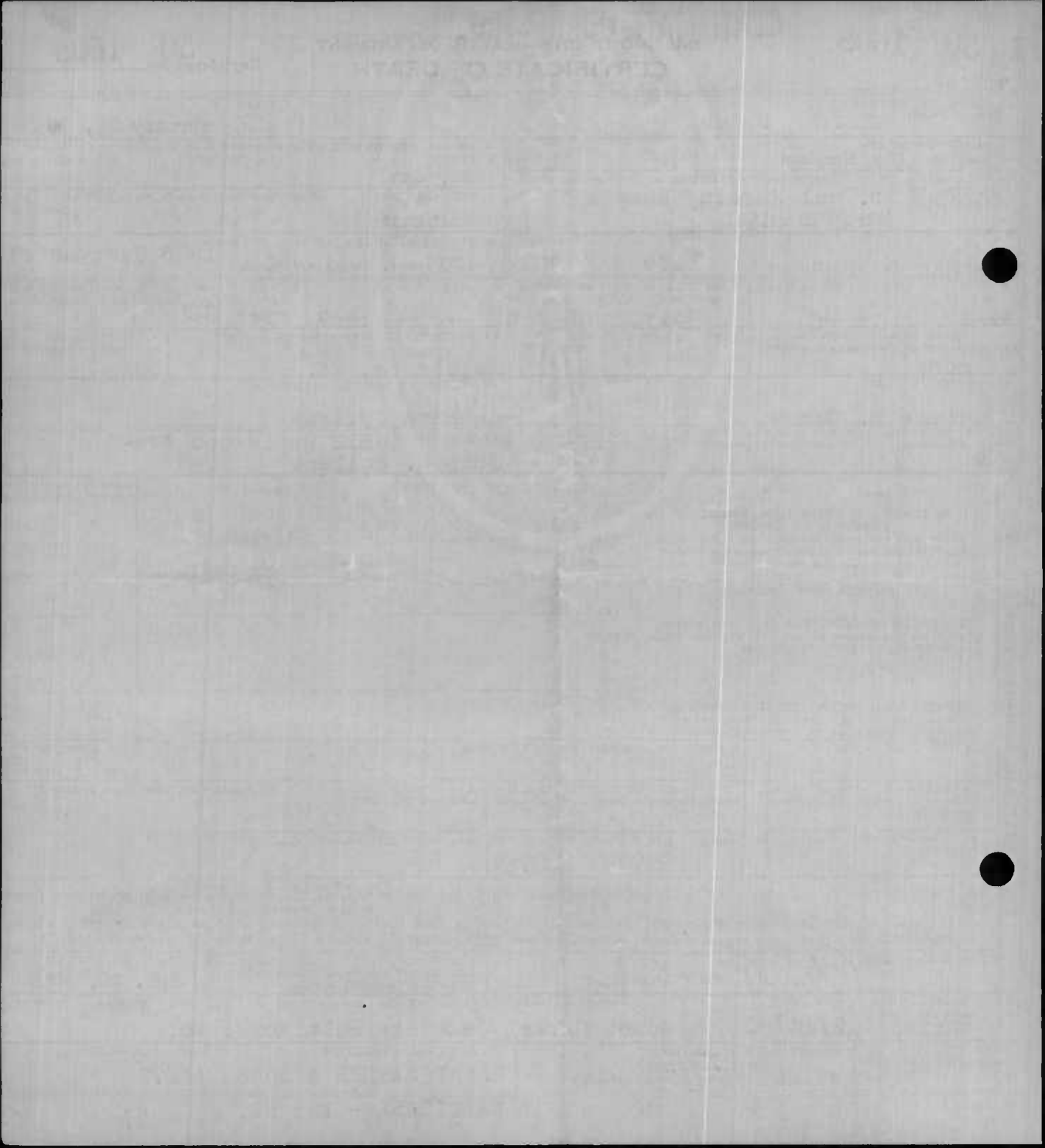
Jack Leverage

2100 Eutaw Pl

Shanahan
1945 W. 1st St
Gr 3317

February 22, 1950

BALTIMORE, - 13, MD.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) WILLIAM Alonzo BRIGHT		2. DATE OF DEATH February 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-03	
D. STREET ADDRESS (If rural, give location) 969 N. Chester Street		E. LENGTH OF STAY IN BALTIMORE Life	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 23, 1891
9. AGE (in years last birthday) 58		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) millworker		10B. KIND OF BUSINESS OR INDUSTRY unknown	
13. FATHER'S NAME Wm. T. Bright		14. MOTHER'S MAIDEN NAME Sophia Obersider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. 217-18-6674	
17. INFORMANT Mrs. Matilda Bright		18. DATE OF DEATH February 23, 1950	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
(A) Status epilepticus DUE TO Idiopathic epilepsy		
(B) _____ DUE TO _____		
(C) _____ DUE TO _____		
19. ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Dr. J. Mc Clafferty</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 2-23-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 2/27/50	24C. NAME OF CEMETERY OR CREMATORY Baltimore National	24D. LOCATION (City, town, or county) (State) Baltimore, Md.		
DATE RECEIVED BY LOCAL REGISTRAR FEB 24 1950		REGISTRAR'S SIGNATURE <i>Matthew J. Williams</i>		25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

OFFICE OF THE STATE HEALTH OFFICER

ALBANY, N. Y.

1911

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426
50 1610BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH420.1 50 1610
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Morton E. Fleischer			2. DATE OF DEATH Feb. 22, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. Maryland 5909 Park Heights Ave B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 5909 Park Heights Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-20		
C. Length of stay in Baltimore 48 yrs. Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 5909 Park Heights Ave.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Mar. 5, 1901	9. AGE (In years last birthday) 48	10. Under 1 Year Months: Days 2 17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Lady's Wear & Women's Clothes		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Samuel Fleisher		14. MOTHER'S MAIDEN NAME Minna Solomon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 075-14-8687		17. INFORMANT ADDRESS Ave Mrs Leon Oppenheimer 5909 Pk. Heights	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) uremia & myocardial failure	CAUSE OF DEATH (A) uremia & myocardial failure DUE TO	INTERVAL BETWEEN ONSET AND DEATH 1 month
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cardio-vascular - renal disease	(B) Cardio-vascular - renal disease DUE TO	2 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Coronary thrombosis 1st attack	(C) Coronary thrombosis 1st attack	7 yrs ago

19A. DATE OF OPERATION ✓	19B. MAJOR FINDINGS OF OPERATION ✓	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) no	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) none	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ✓
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY ✓	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? ✓

22. I hereby certify that I attended the deceased from **1943**, 19th, to **Feb 22**, 1950, that I last saw the deceased alive on **Feb 22**, 1950, and that death occurred at **12:30** p. m., from the causes and on the date stated above.

23A. SIGNATURE J. Frederick Lark	23B. ADDRESS Temple Gardens	23C. DATE SIGNED 2/23-50
--	---------------------------------------	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb. 24, 1950	24C. NAME OF CEMETERY OR CREMATORY Baltimore, Hebrew	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
--	-----------------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR FEB 24 1950	REGISTRAR'S SIGNATURE Harriet M. Williams, M.D.	25. FUNERAL DIRECTOR David Sondheim & Son	ADDRESS 1902 Eutaw Pl.
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50 1611

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1611
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Reuben Hill

2. DATE
OF
DEATH

2-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

112 Hamerbocker Court

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, City 23-01

D. STREET ADDRESS (If rural, give location)

112 Hamerbocker Court Hammerbocker

C. Length of stay in Baltimore

50 yrs

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

8. DATE OF BIRTH

9. AGE (in years
last birthday)If Under 1 Year
Months Days Hours Min.

85

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, or if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Retired

OPA

11. BIRTHPLACE (State or foreign country)

Augusta Georgia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

No

17. INFORMANT

ADDRESS

Robert C. Hill-1734 N. Broadway

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypostatic pneumonia

2 wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 19, 1950, to Feb 20, 1950, that I last saw the
deceased alive on Feb 19, 1950, and that death occurred at 1:25 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

B. V. Benjamin

M. D.

834 Sharp St.

2-23-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

2/24/50

MT Calvary

A. A. Co., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

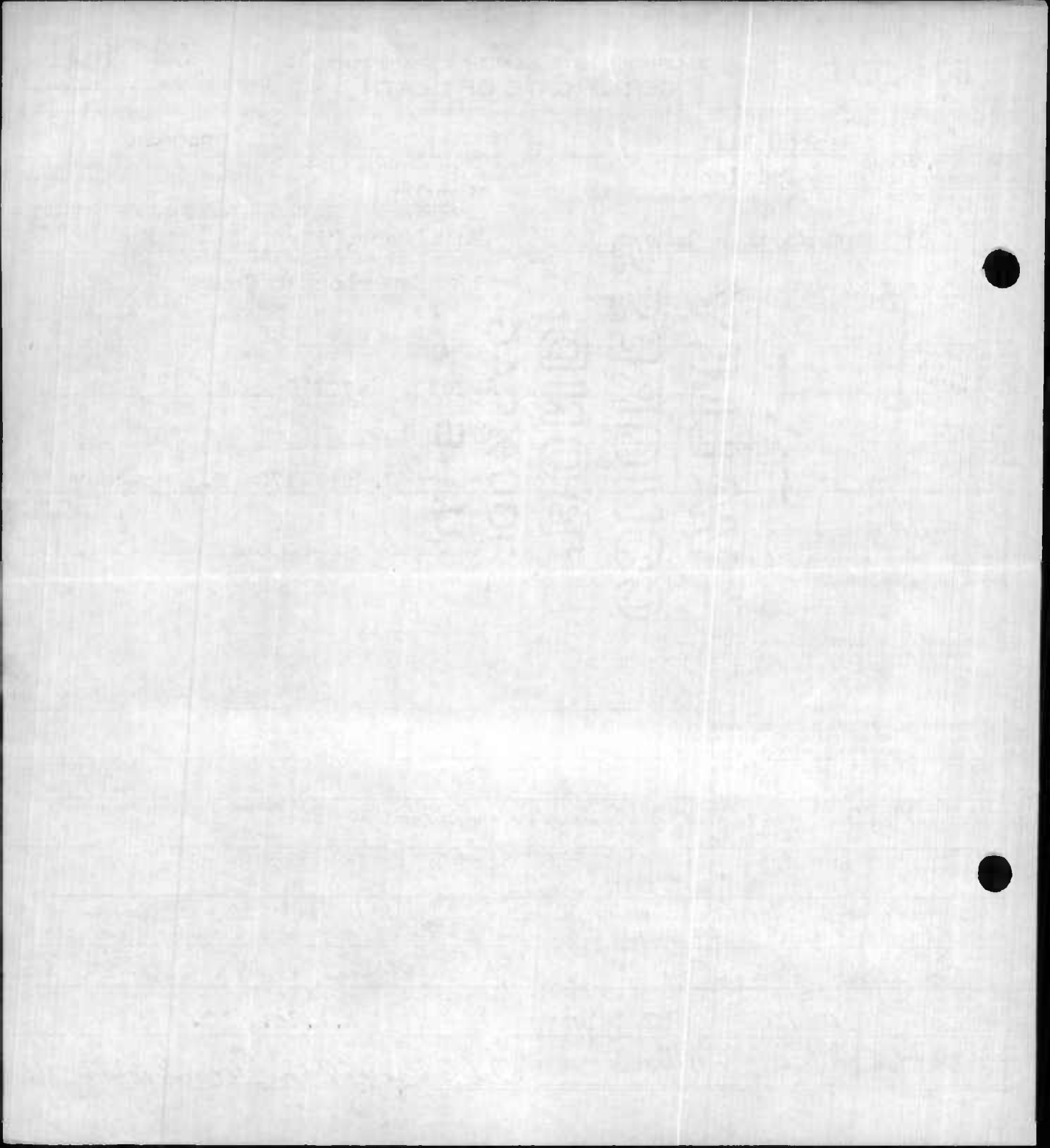
25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

R. L. Brown

108 W. Montgomery St



C-6 26
50 1612BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 1612

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>James Thomas Carriger</i>		2. DATE OF DEATH <i>2-21-1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>909 N. Carrollton Ave.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> <i>16-01</i>	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>909 N. Carrollton Ave.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 22, 1873</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, if not retired) <i>Porter-Office B & O R.R.</i>		9. AGE (in years last birthday) <i>76</i>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Johnson City Tenn.</i>	
13. FATHER'S NAME <i>William Carriger</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		14. MOTHER'S MAIDEN NAME <i>Mary P.</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Thomas V. Carriger</i>	
		ADDRESS <i>909 N. Carrollton Ave.</i>	

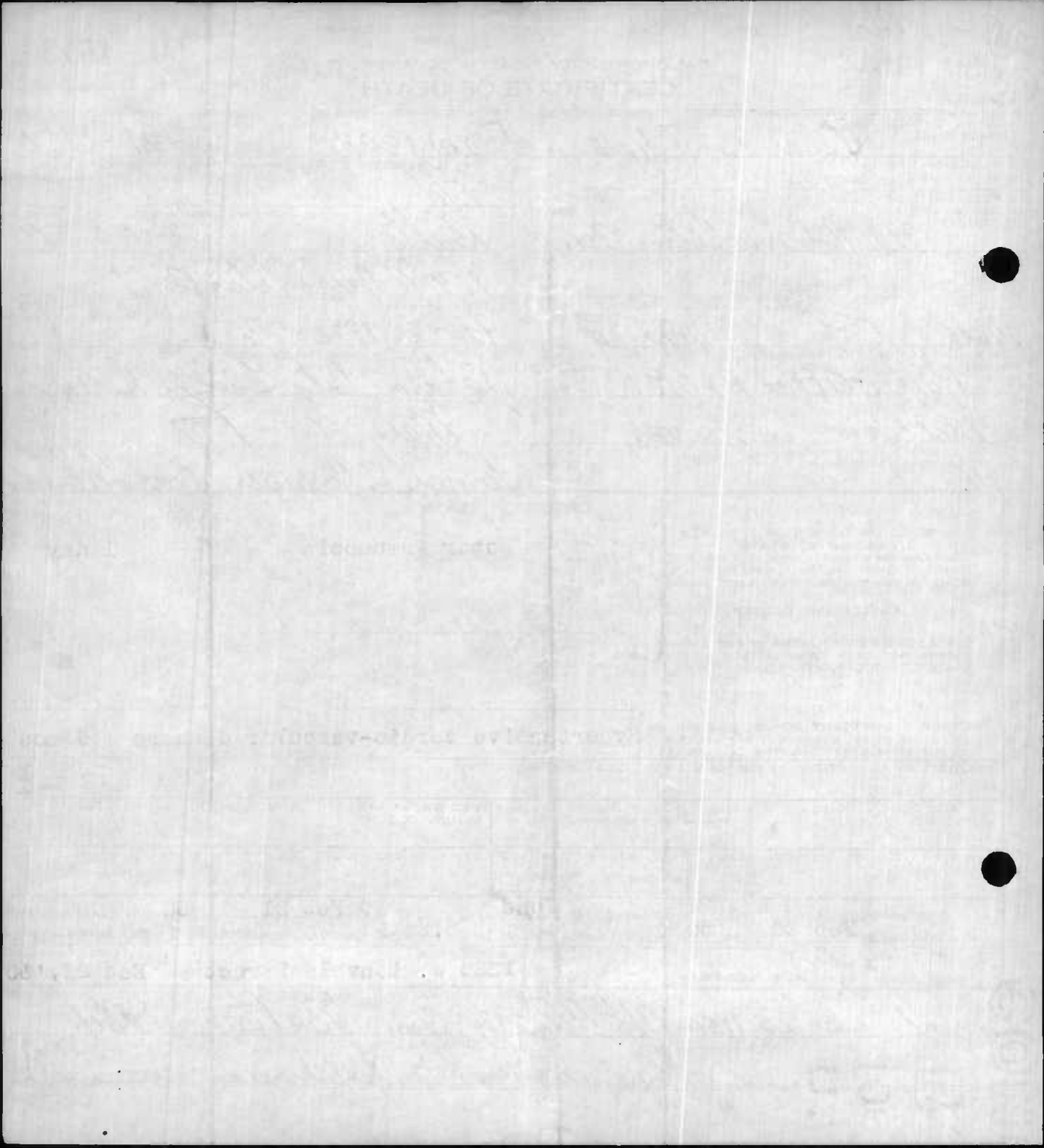
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) <i>Lobar Pneumonia</i>		<i>1 day</i>
DUE TO (A) _____		
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertensive cardio-vascular disease</i>		<i>9 mos</i>
DUE TO (B) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
DUE TO (C) _____		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 19 49</i> to <i>Feb 21</i> , 1950 that I last saw the deceased alive on <i>Feb 20</i> , 1950, and that death occurred at <i>5.25 P.</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>Robert R. Tinsley</i>		23B. ADDRESS <i>1325 W. Lanvale Street</i>		23C. DATE SIGNED <i>Feb 23, '50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2-25-1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>	
24D. LOCATION (City, town, or county) <i>Balto.</i>		24E. LOCATION (City, town, or county) <i>MD.</i>		24F. LOCATION (City, town, or county) <i>MD.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>William M. Williams</i>		25. FUNERAL DIRECTOR <i>Mrs. Kate R. Williams</i>	
				ADDRESS <i>322 N. Schroeder St.</i>	

FEB 24 1950

75047

108



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1613
Registered No. _____

BIRTH NO. 49-13794

1. NAME OF DECEASED
(Type or Print) **EDWARD SHIELDS**

2. DATE
OF DEATH **February 22, 1950**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE **Maryland**
B. COUNTY _____

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE
University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

Length of stay in Baltimore _____

D. STREET ADDRESS (If rural, give location)
725 Sarah Ann St.

5. SEX **male**
6. COLOR OR RACE **colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
SINGLE

8. DATE OF BIRTH
JUNE 28, 1949

9. AGE (In years last birthday)
10. Under 1 Year Months Days
11. Under 24 Hours Hours Min.
8

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Balto. Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Edward Riddick

14. MOTHER'S MAIDEN NAME

Hazel Shields

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

Hazel Shields ADDRESS **725 Sarah Ann St.**

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE
Earl L. Royce

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
M.D. **Feb. 23, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Feb. 25, 1950

mt. Auburn

Baltimore

md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

William Williams, M.D.

Mrs. Kate Williams ADDRESS **3224**

CERTIFICATE OF DEATH

RETURN TO HEALTH DEPARTMENT

FILED IN

LOCAL HEALTH DEPARTMENT

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE

TIME

PLACE

BY

SIGNATURE

PRINTED NAME

RELATIONSHIP

DATE

TIME

PLACE

BY

SIGNATURE

PRINTED NAME

RELATIONSHIP

W-516
50 1614BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1614
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) **THAD WIMBERLY**2. DATE
OF DEATH **February 22, 1950**3. PLACE OF DEATH:
A. **Baltimore City, Maryland**4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)
A. STATE **Maryland**
B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION **Franklin Square Hospital**C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore **16-01**

D. STREET ADDRESS (If rural, give location)

1111 Harlem Avenue

length of stay in Baltimore

Yrs.
Mos.
Days5. SEX **male**6. COLOR OR RACE **colored**7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH

Feb. 17, 18999. AGE (in years last birthday) **51**

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Edgecomb Co. N.C. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Richard Wimberly

14. MOTHER'S MAIDEN NAME

Livia Pettaway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

Annie Wimberly Harlem Ave

ADDRESS

18. **E 919.0**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Bullet wound of heart.**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. ☐21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **home**21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **1111 Harlem Avenue**21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **February 22, 1950 9.30a.m.**21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒21F. HOW DID INJURY OCCUR? **burlap bag caught in some object when removing from Bullet accidentally released when triggered**22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Earl L. Ryer

M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒23C. DATE SIGNED **Feb. 23, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

Feb 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Barbers

24D. LOCATION (City, town, or county) (State)

North Carolina

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, Jr.

25. FUNERAL DIRECTOR

Mrs. Katie P. Williams SchweigertADDRESS **322 Y**

1911

RECEIVED

1911

1911

RECEIVED

1911

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C-50²⁰⁰ 1615BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1615
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edward

J.

Chase

N-861.4

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hospital

Length of stay in Baltimore

Yrs.
Mos.
Days5. SEX
M6. COLOR OR RACE
C7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Oct 28, 1939

9. AGE (In years
last birthday)

20

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ba lto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James

Holloway

14. MOTHER'S MAIDEN NAME

Elizabeth Chase

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Elizabeth Chase W. Mulberry St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Hemoperitoneum

DUE TO Gunshot wound of abdomen with laceration
of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

7 W. Redwood St.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Feb. 22, 1950 7 P m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Firearms

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

R S Fisher

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Feb. 23, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2-27-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Zion Cem

24D. LOCATION (City, town, or county) (State)

Lansdowne Md.

REGISTRAR'S SIGNATURE

Franklin M. Williams

25. FUNERAL DIRECTOR

Mrs. Katie R. Williams

ADDRESS

322 N Schroeder St

THE STATE OF TEXAS
COUNTY OF DALLAS

Handwritten signature or mark in the top left corner.



W-362
50 1616BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1616

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jessie Waters		2. DATE OF DEATH 2-23-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 18-02	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 413 N Carrollton Ave	
5. SEX male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH July 14, 1895
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		11. BIRTH PLACE (State or foreign country) Georgia	
10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME COSSAN WATERS		14. MOTHER'S MAIDEN NAME Luvicer ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Sarah Waters Carrollton Ave		ADDRESS 413 N	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) Salmonella Septicemia	INTERVAL BETWEEN ONSET AND DEATH 20 Days
ANTECEDENT CAUSES	(B) Salmonella Enteritis	24 Days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) PARALYTIC Ileus	10 Days

19A. DATE OF OPERATION 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-6**, 19**50**, to **2-23**, 19**50**, that I last saw the deceased alive on **2-23**, 19**50**, and that death occurred at **1000** A. M., from the causes and on the date stated above.

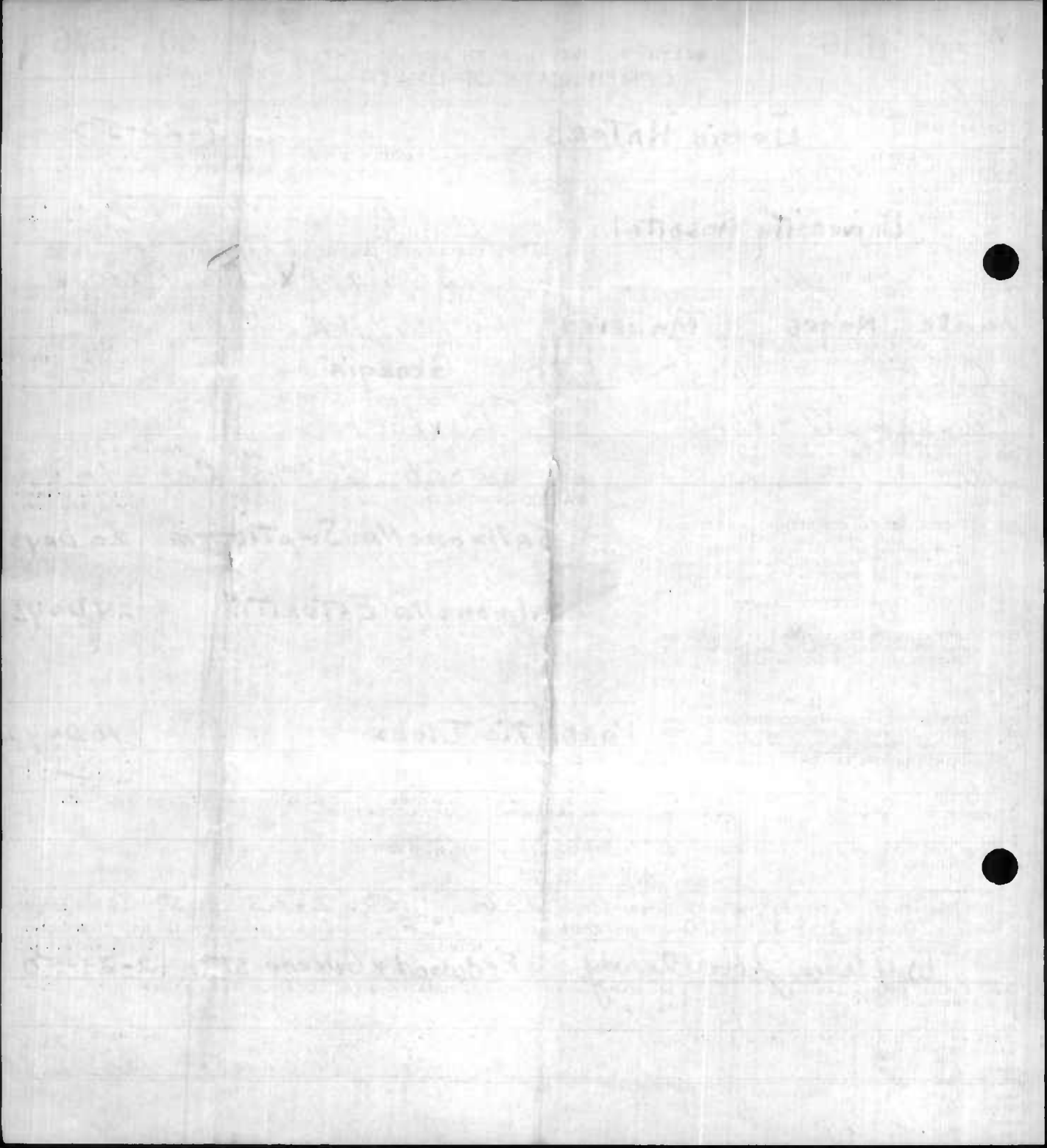
23A. SIGNATURE William J. Hollaway	23B. ADDRESS Redwood & Greene STS.	23C. DATE SIGNED 2-23-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb 26, 1950	24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) Baltimore Md
DATE RECEIVED BY LOCAL REGISTRAR FEB 24 1950	REGISTRAR'S SIGNATURE William J. Hollaway	25. FUNERAL DIRECTOR Mrs. Katie Williams	ADDRESS 322 N Schroeder St

VS 150

72071

122B



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 1617

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARIE

WALKER

2. DATE
OF
DEATH

February 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

601 Pierce Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

601 Pierce Street

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Sept. 9, 1897

9. AGE (In years last birthday)

52

10 Under 1 Year Months Days
11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Accomac Co. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Walker

14. MOTHER'S MAIDEN NAME

Willie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Horace Kellum Saratoga St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Broncho pneumonia**
due to bilateral

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

23A. SIGNATURE

W. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED
Feb. 20, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-24-1950

24C. NAME OF CEMETERY OR CREMATORY

W. H. Calverton Cem. Baltor

24D. LOCATION (City, town, or county) (State)

Md.

DATE RECEIVED BY LOCAL REGISTRAR

2/23/50

REGISTRAR'S SIGNATURE

W. J. Mc Clafferty

25. FUNERAL DIRECTOR

W. K. Williams

ADDRESS

822

D-262
50 1618BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1618
Registered No.

BIRTH NO. 50-03685

1. NAME OF DECEASED
(Type or Print) BABY DEGROSS2. DATE
OF DEATH February 22, 19503. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION Laurens
1804 Lawrence StreetC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 15-2

Length of stay in Baltimore 4 Weeks

D. STREET ADDRESS (If rural, give location)
1804 Lawrence Street

5. SEX male 6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH Feb. 23, 1950

9. AGE (In years last birthday) 11 Under 1 Year Months: Days 4 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Baltimore, Md.12. CITIZEN OF WHAT COUNTRY?
U.S.

13. FATHER'S NAME

Owen Denis De Gross

14. MOTHER'S MAIDEN NAME

Bernie Angelo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Mrs. Bernie De Gross 1804 Lawrence St.

18. 7620

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration of meconium during birth

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy therewith and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

E. L. Royer

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....23C. DATE SIGNED
Feb. 23, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

VS 157

R. P. Nelson 1303 Pennington St.

160c

47131

F-655

50 1619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES HENRY FOREMAN

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

5. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONGood Samaritan Home
27 N. Carey StreetC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

27 N. Carey Street

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 3, 1868

9. AGE (In years,

last birthday)

81

11. Under 1 Year

Months

Days

12. Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Janitor

10B. KIND OF BUSINESS OR
INDUSTRY

R.R. Station

11. BIRTHPLACE (State or foreign country)

Sandy Spring, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel Foreman

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

Mrs. Jesse Peaker
2438 Woodbrook Ave.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Hypertensive + arteriosclerotic
Cardiovascular disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 June, 1949, to 22 Feb., 1950, that I last saw the
deceased alive on 22 Feb., 1950, and that death occurred at 7 4 m., from the causes and on the date stated above.

23A. SIGNATURE

Emil H. Henning Jr.

M. D.

23B. ADDRESS

601 Winans Way

23C. DATE SIGNED

23 Feb 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Feb. 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams, M.D.

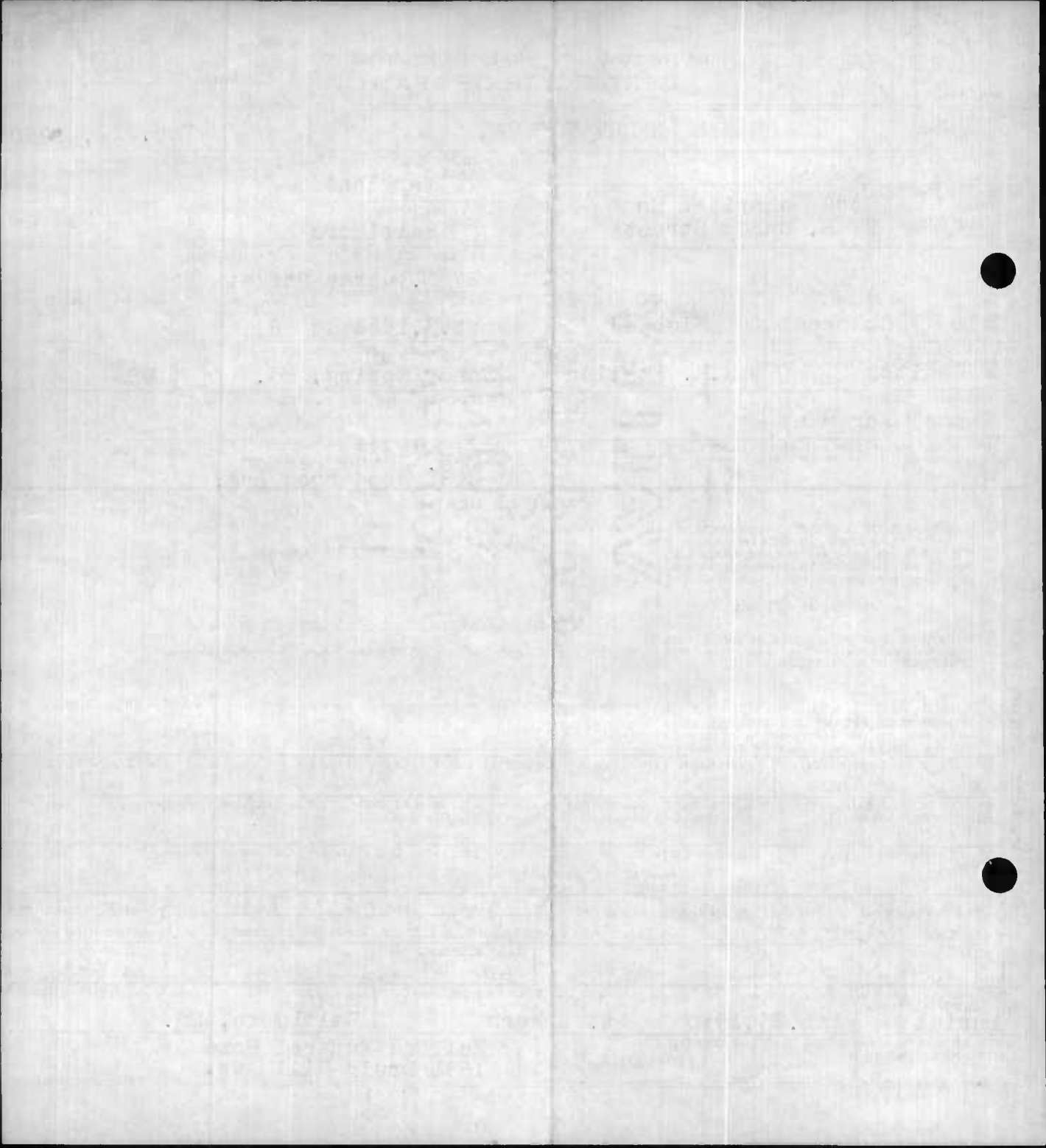
25. FUNERAL DIRECTOR

Holland Funeral Home
1631 Druid Hill Ave.

ADDRESS

FEB 24 1950

MEDICAL CERTIFICATION



50 1620

Dr. *William* 1920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 751

Registered No. _____

BIRTH NO. *49-16581*1. NAME OF DECEASED
(Type or Print)*Islen Murray*2. DATE
OF
DEATH*Feb. 23, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1641 N. Bayson St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-02

D. STREET ADDRESS (If rural, give location)

1641 N. Bayson St.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug. 1, 1949

9. AGE (In years last birthday)

6

If Under 1 Year

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Thomas Murray

14. MOTHER'S MAIDEN NAME

Marie Farrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

*John T. Murray N. Bayson St.*ADDRESS *1641*

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Spine Bifida

INTERVAL BETWEEN ONSET AND DEATH

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Aug 7, 1949* to *Feb. 22, 1950*, that I last saw the deceased alive on *Feb. 22, 1950* and that death occurred at *7:00 p.m.* from the causes and on the date stated above.

23A. SIGNATURE

Dr. William H. Williams, M.D.

23B. ADDRESS

410 N. Guilford St.

23C. DATE SIGNED

2/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Feb. 1950

24C. NAME OF CEMETERY OR CREMATORY

St. Peters

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Dr. William H. Williams, M.D.

25. FUNERAL DIRECTOR

Frederick Funeral Home

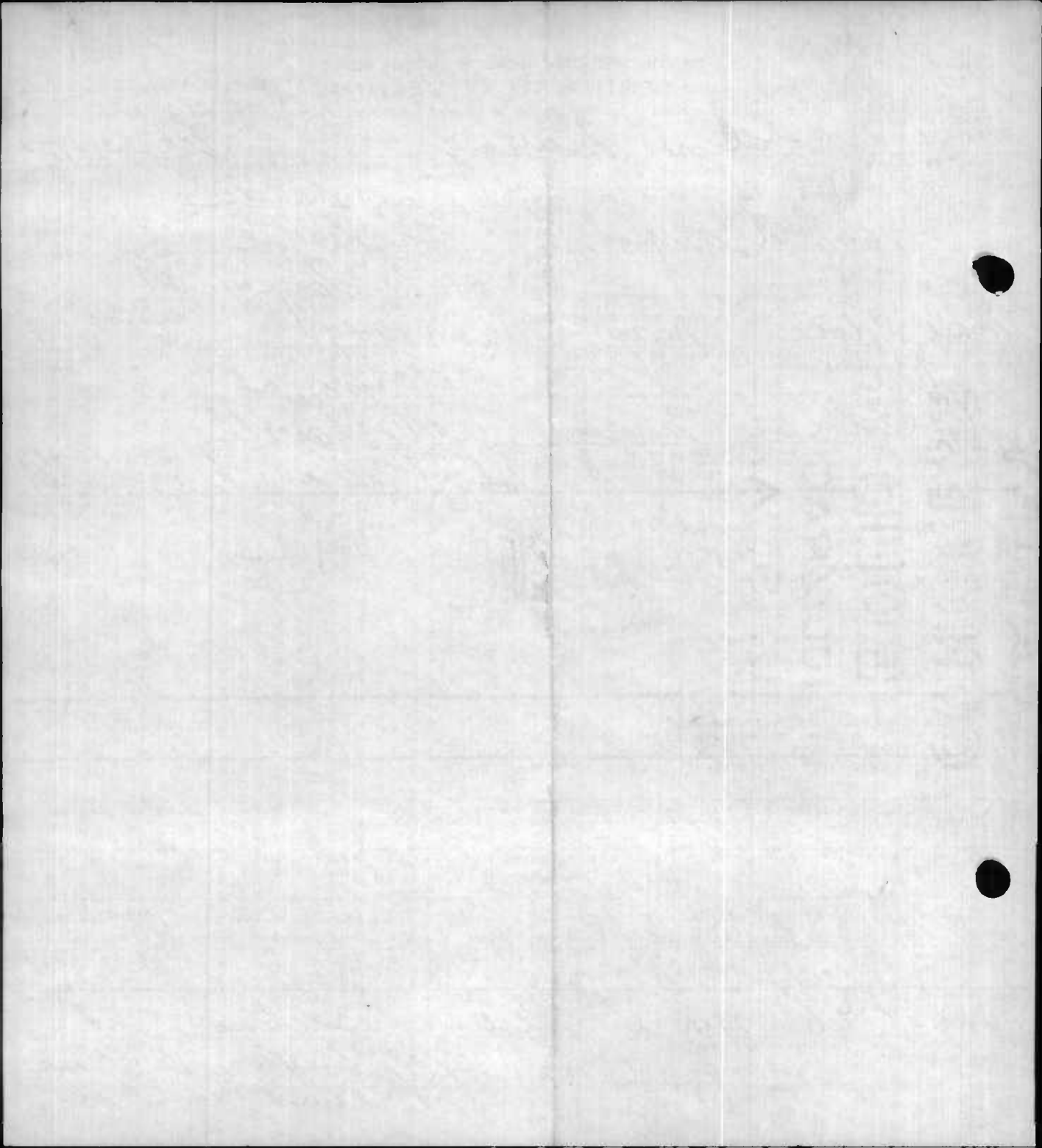
ADDRESS

1631 Druid Hill Ave.

FEB 24 1950

157B

MEDICAL CERTIFICATION



J-525
50 1621BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1621

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
A. STATE B. COUNTY before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/20, 1950, to 2/22, 1950, that I last saw the
deceased alive on 2/21, 1950, and that death occurred at 5:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

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94a

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

ALBANY

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2

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Frank Phillips

2. DATE
OF
DEATH

FEB 22 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

502 Gold St

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years; last birthday)

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebro-vascular accident*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Myocardial infarction*
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2-22*, 19*50*, to *2-22*, 19*50*, that I last saw the deceased alive on *2-22*, 19*50*, and that death occurred at *7:20 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

Walter L. Aron M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

2/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

2262V

Holland Funeral Home
46-74 Grandville Ave.

To be signed by medical examiner

non-med. Examiner's case 93D

NOT A MEDICAL EXAMINER'S CASE
John R. Davis, M.D.

Per *J. R. Fisher* M.D.
CHILD OR ADULT MEDICAL EXAMINER

A-425
50 1623BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1623
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SAVERIO Alagna

2. DATE
OF
DEATH

2-23-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE
Maryland

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

West BALT. Gen'l Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore

16-06

township)

D. STREET ADDRESS (If rural, give location)

720 Poplar Grove St.

Length of stay in Baltimore

45 Yr.

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

February 22 1897

9. AGE (In years last birthday)

53

If Under 1 Year Months: Days Hours: Min.

1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Barber

10B. KIND OF BUSINESS OR INDUSTRY

Barber Shop

11. BIRTHPLACE (State or foreign country)

Marsala

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Frank Alagna

14. MOTHER'S MAIDEN NAME

Angelina Parinello

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

First W. W.

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Frank Alagna (Son) 720 Poplar Grove St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Acute coronary occlusion with myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Acute pulmonary edema.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-23-1950 to 2-23-1950, that I last saw the deceased alive on 2-23-1950, and that death occurred at 1 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Feb. 27 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

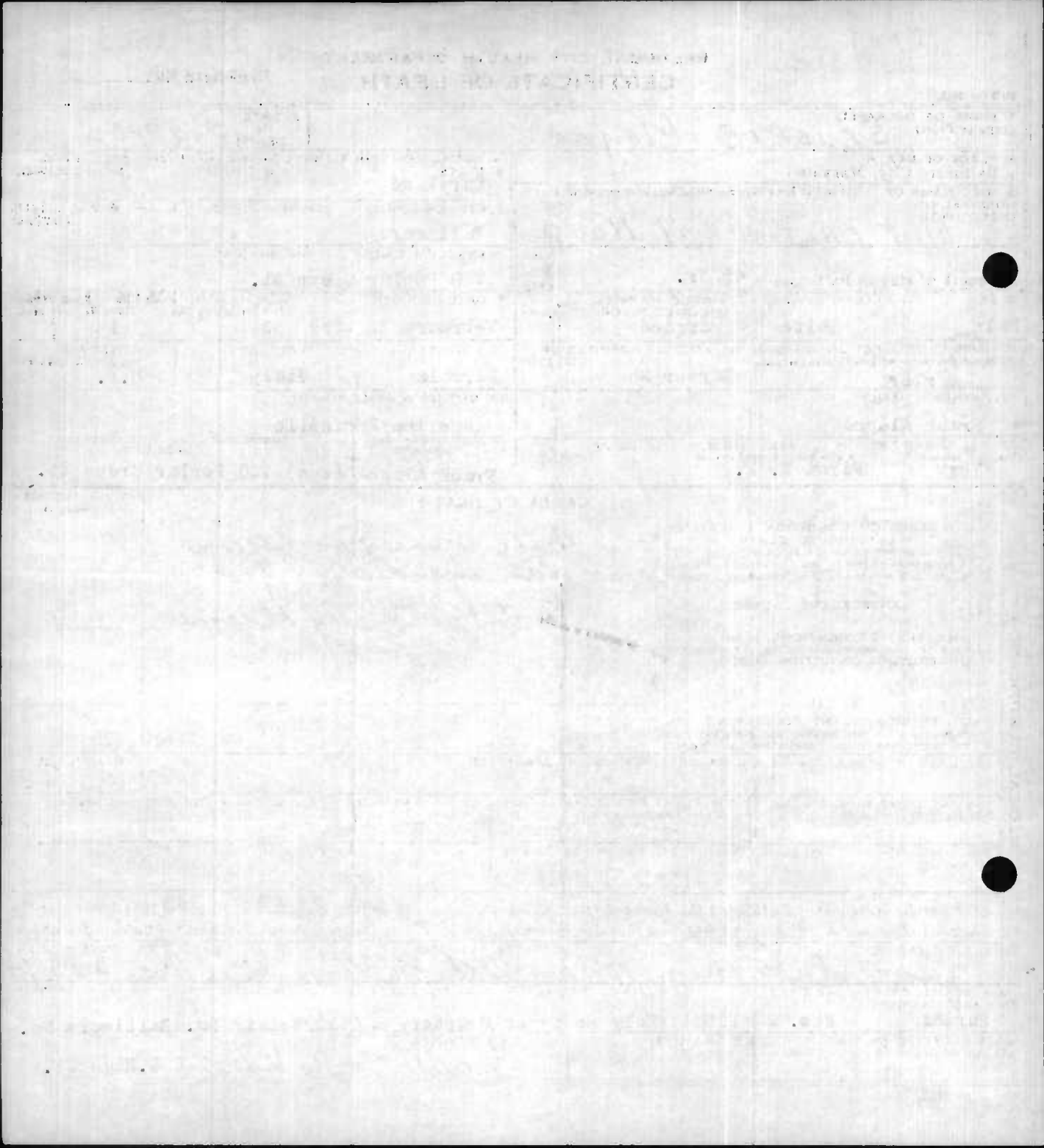
ADDRESS

William M. Williams, M.D.

Frank Della Noce 322 S. High St.

FEB 24 1950 70089

94a



F-652

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1624

BALTIMORE CITY HEALTH DEPARTMENT

50

1624

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Wm. Farrington.

76018

2. DATE
OF
DEATH

FEB 24 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Ohio,

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

CINCINNATI,

D. STREET ADDRESS (If rural, give location)

7143 E. FAWN Dr.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

baby

8. DATE OF BIRTH

9-27-49

9. AGE (in years,
last birthday)

4

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Aspiration Pneumonia

2 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Congenital Heart Disease

Retro-esophageal vessel

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-7-1950 to 2-24-1950 that I last saw the
deceased alive on 2-24-1950, and that death occurred at 12:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Thomas C. McRae, M. D.

JOHNS HOPKINS HOSPITAL

2-24-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

VS 150

157E

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of deceased *James M. [illegible]*
2. Age *65*
3. Sex *Male*
4. Date of death *May 15, 1910*
5. Place of death *at home*
6. Cause of death *Heart failure*
7. Signature of physician *[illegible]*
8. Signature of registrar *[illegible]*

R-224
50 1625BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1625

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Johanna Josephine Reuschling		2. DATE OF DEATH Feb.-23-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY City	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 1512 N.Chapel Street 60		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-06	
Length of stay in Baltimore 35Yrs. Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1512 N.Chapel Street	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept.5th.,1889
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 60
13. FATHER'S NAME Lawrence O'Dwyer		11. BIRTHPLACE (State or foreign country) Virginia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. None		14. MOTHER'S MAIDEN NAME Mary Carney	
17. INFORMANT John L.Reuschling--2803 E.Federal Street		ADDRESS	

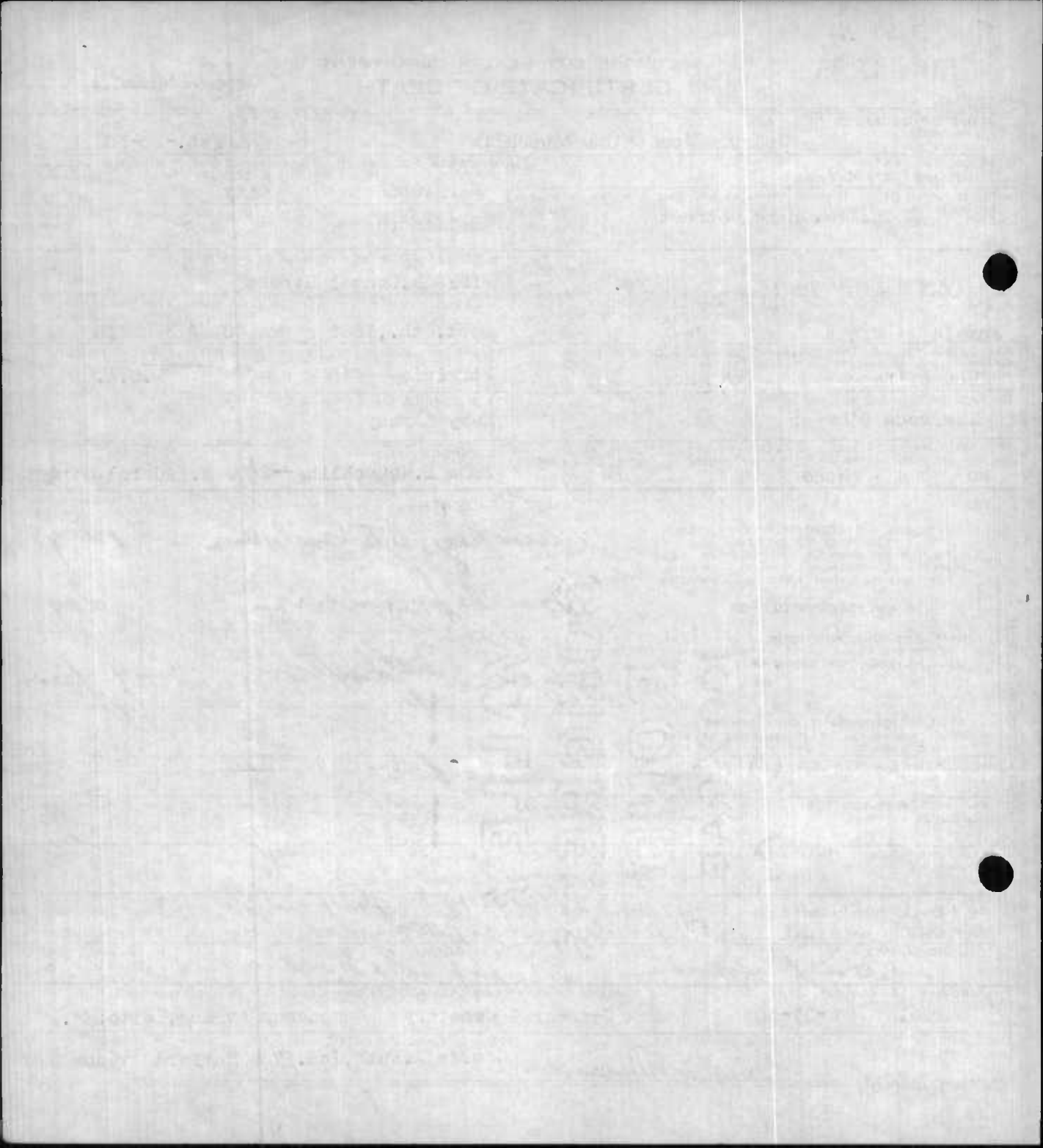
MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Hemorrhage into Cerebrum (A) DUE TO Broncho pneumonia (B) DUE TO Chronic Nephritis (C)		INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 4 years	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug 19, 1946 , to Feb 23, 1950 , that I last saw the deceased alive on 2/23, 1950 , and that death occurred at 12:55 p.m. , from the causes and on the date stated above.			
23A. SIGNATURE Myron L. Solomon M. D.		23B. ADDRESS 129 S. Broadway	23C. DATE SIGNED 2/24/50.
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2-27-50	24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	24D. LOCATION (City, town, or county) (State) Edmondson Avenue, Balto: Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE William M. Williams, M.D.	25. FUNERAL DIRECTOR ADDRESS George J. Ruth, Inc. 1735 Harford Avenue	

FEB 24 1950

1627

1210



R-262
50 1626BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1626
Registered No.

BIRTH NO. 50-03822

1. NAME OF DECEASED
(Type or Print)

Baby girl Rogers

2. DATE
OF
DEATH

2-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write full name and give township)

Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MARDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb 21, 1950, to Feb 24, 1950, that I last saw the deceased alive on Feb 24, 1950, and that death occurred at 3 H m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (Specify)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

160a

L-125
50 1627BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1627
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Roland Lipscomb		2. DATE OF DEATH Feb. 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23 19-01	
D. STREET ADDRESS (If rural, give location) 406 Bruce St.		E. DATE OF BIRTH 1929	
F. SEX M		G. AGE (In years last birthday) 20	
H. COLOR OR RACE C		I. Under 1 Year Months: Days: 8 21 29	
J. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single		K. Under 24 Hours Hours: Min. 29	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General utility		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Lipscomb		14. MOTHER'S MAIDEN NAME Montecello Askew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Montecello Lipscomb		ADDRESS 406 Bruce St.	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) I Crushed skull	CAUSE OF DEATH I Crushed skull	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(A) DUE TO (B) DUE TO (C) DUE TO	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Railroad tracks	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Pa. underpass at Edmondson Found lying between wall of N.B. track & A.V. track
21D. TIME (Month) (Day) (Year) (Hour) Feb. 19, 1950 ? m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Found lying beside railroad tracks 20-2
22. I certify that I took charge of the remains described above, held an Insp. & In. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE Earl L. Royer	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>	23C. DATE SIGNED Feb. 20, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/25/50	24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	24D. LOCATION (City, town, or county) (State) A. A. Co. Md.
DATE RECEIVED BY LOCAL REGISTRAR Feb. 24 1950	REGISTRAR'S SIGNATURE William H. Williams	25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc.	26. ADDRESS 169

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of *Albany*

7

2

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED **MONTGOMERY**
(Type or Print) **CATHERINE A THOMPSON**

2. DATE OF DEATH **February 23, 1950**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE **Maryland**
B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION
Johns Hopkins Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
550 Oxford Street

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX **female**
6. COLOR OR RACE **colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
m.

8. DATE OF BIRTH **Nov. 4-1897 52**
9. AGE (In years last birthday) **52**
If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Talbot Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
Frank Miller

14. MOTHER'S MAIDEN NAME
Virginia Flood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Conrad Thompson-550 Oxford

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Pulmonary edema due to hypertensive cardiovascular disease**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE
Earl L. Boyer

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR

23C. DATE SIGNED
Feb. 24, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE
2/28/50

24C. NAME OF CEMETERY OR CREMATORY
Mt. Calvary

24D. LOCATION (City, town, or county) (State)
A. B. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE
William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS
Samuel W. Sullivan, Jr.

FEB 24 1950

VS 151

15009201 to 1340 Arlington Ave

MEDICAL CERTIFICATION

By State - please write the cause of death clearly and legibly.

2

TO THE DEATH

1900

1

1

M-255
50 1629BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1 50 1629

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mc Cammon - Emily

2. DATE
OF
DEATH

Feb. 24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Franklin Square Hospital

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House wif

10B. KIND OF BUSINESS OR
INDUSTRY

at Home

13. FATHER'S NAME

Theodore Hinton

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

25-05

D. STREET ADDRESS (If rural, give location)

1301 Patapsco Ave.

8. DATE OF BIRTH

8-3-1895

9. AGE (In years
last birthday)

54

11 Under 1 Year
Months: Days12 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

14. MOTHER'S MAIDEN NAME

Sarah Skinner

17. INFORMANT

ADDRESS

Mrs Lawrence P. McGarrity Patapsco

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Cerebral hemorrhage
Cardio-vascular

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerotic disease

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Diabetes mellitus

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-20, 1950, to 2-24, 1950, that I last saw the
deceased alive on 2-24, 1950, and that death occurred at 1:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950
VS 150

William M. Williams

John J. Cowan & Son

2301 Hollins
St.

0500001651

61

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of medical examiner		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
33. Signature of burial place		34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
37. Signature of burial place		38. Signature of burial place		39. Signature of burial place		40. Signature of burial place	
41. Signature of burial place		42. Signature of burial place		43. Signature of burial place		44. Signature of burial place	
45. Signature of burial place		46. Signature of burial place		47. Signature of burial place		48. Signature of burial place	
49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHNSON, PEARL MOBLEY

2. DATE
OF
DEATH

2/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Provident

Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

Yrs.
Mos.
Days

8. DATE OF BIRTH

6/20/96

9. AGE (In years
last birthday)

53

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR
INDUSTRY

Charwoman

13. FATHER'S NAME

Peter Mobley

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS
wash. D.C.

Mrs. Ruth Smith, 1640 N.J. Ave. N.W.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Pneumonia (Hypostatic)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Hepatic Insufficiency

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/19, 1950 to 2/23, 1950, that I last saw the
deceased alive on 2/23, 1950, and that death occurred at 8 P m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE 2-27-50

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

24D. LOCATION (City, town, or county)

Washington D.C.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

malvan & Lehey Inc. 434-A S.W.

CERTIFICATE OF DEATH

STATE OF NEW YORK

IN SENATE

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D-162
50 1631BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 1631
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

REINHOLD DUBERKE

2. DATE
OF
DEATH

FEB. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

BON SECOURS.

MARYLAND

HARFORD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

CHURCHVILLE (RURAL)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

4

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years;
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

MALE WHITE

SINGLE

APRIL 13, 1875

74

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

FARM HAND

10B. KIND OF BUSINESS OR INDUSTRY

FARM.

11. BIRTHPLACE (State or foreign country)

STOLP, GERMANY

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

HERMAN DUBERKE

14. MOTHER'S MAIDEN NAME

AUGUSTA LUX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MRS. REUBEN UPTON

ADDRESS
110-2nd Ave., S.W.
GLEN BURNIE, MD.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Esophagus

DUE TO

4 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Post-operative shock

DUE TO

16 HRS.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

2-20-50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Esophagus

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/18, 1950, to 2/22, 1950 that I last saw the deceased alive on 2/22, 1950, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Joseph R. Dolce

23B. ADDRESS

M. D.

Bon Secours Hosp.

23C. DATE SIGNED

2/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

FEB. 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

GLEN HAYEN

24D. LOCATION (City, town, or county)

GLEN BURNIE, MD.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

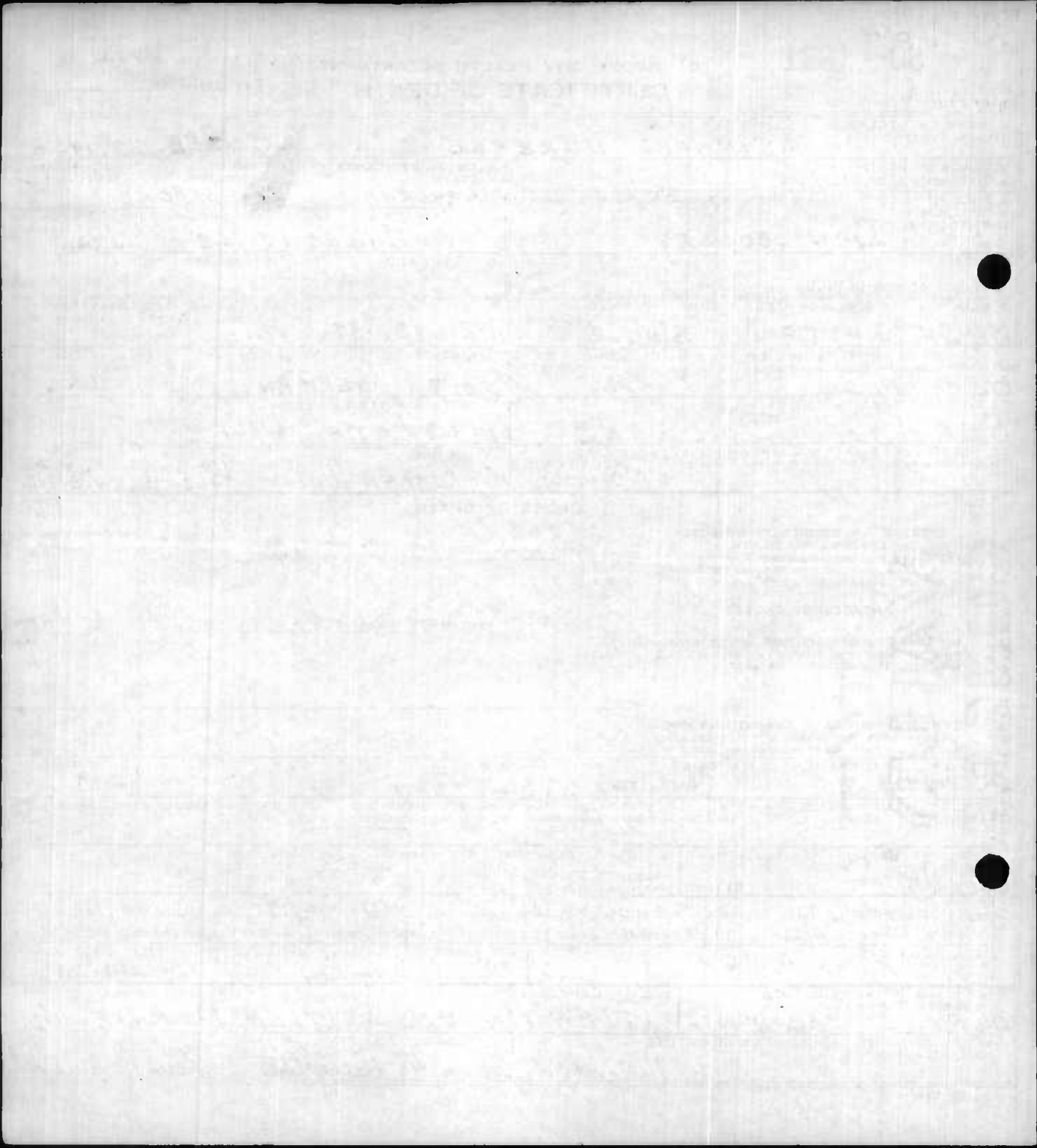
25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

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46a



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 593 50 16321. NAME OF DECEASED
(Type or Print)Andrew Reaves (Reed)2. DATE
OF
DEATHFEB 22 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)JOHNS HOPKINS HOSPITAL4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 14-03D. STREET ADDRESS (If rural, give location)
1800 Division St

Length of stay in Baltimore

25 yrsYrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)Married

8. DATE OF BIRTH

12-4-039. AGE (In years
last birthday)4610 Under 1 Year
Months; Days11 Under 24 Hours
Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

Md. SLAG CO.

11. BIRTHPLACE (State or foreign country)

N.C.12. CITIZEN OF
WHAT COUNTRY?U.S.A.

13. FATHER'S NAME

ALBERT REAVES

14. MOTHER'S MAIDEN NAME

CARRIE15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)NoNo16. SOCIAL
SECURITY NO.230-08-6462

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Glomerulonephritis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C) Aortic insufficiency and
congestive failure

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-20-1949 to 2-22-1950, that I last saw the deceased alive on 2-22-1950, and that death occurred at 6:15 p.m. from the causes and on the date stated above.

23A. SIGNATURE

William W. Winternitz

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

Feb 23, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)BURIAL

24B. DATE

Feb 23, 1950

24C. NAME OF CEMETERY OR CREMATORY

MT. AUBURN CEM

24D. LOCATION (City, town, or county)

BALTO MD

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William W. Winternitz, M.D.

25. FUNERAL DIRECTOR

ADDRESS

CHAS. G. COOPER-512 N. CARROLLTON AV

FEB 24 1950

VS-150

88825

1550000

1312

1950

TO BE APPROVED BY

MEDICAL EXAMINER

1633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 1633

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK ANTHONY HABER

2. DATE
OF
DEATH

Feb. 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTIONUS Marine Hospital
Wyman Pk. Drive & 31st St.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

3130 Harview Avenue

E. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

2/21/94

9. AGE (In years
last birthday)

56

10. Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Policeman

10B. KIND OF BUSINESS OR
INDUSTRY

Balto City

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Haber- Maryland

14. MOTHER'S MAIDEN NAME

Ida Kummer- Germany

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH and edema
Lobular pneumonia; pulmonary congestion
Urinary tract infection with abscess of
right kidney

DUE TO

INTERVAL BETWEEN
ONSET AND DEATHfew days
unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.Injury cervical spinal cord with paraly-
sis, due to fracture of vertebra

DUE TO

Dec. 28, 1949

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Cirrhosis of liver

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

CERTIFICATION APPROVED BY

H. J. McChafferty
M. D.
OR ASST. MEDICAL EXAMINER.

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

Accident - 12/28/49

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3130 Harview Ave. Balto, Md.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

12/28/49 about 1 AM m.

21E. INJURY OCCURRED

WHILE AT ☐ WORKNOT WHILE ☒ AT WORK

21F. HOW DID INJURY OCCUR?

Fell down a flight of stairs

22. I hereby certify that I attended the deceased from Dec. 28, 1949, to Feb. 22, 1950, that I last saw the deceased alive on Feb. 22, 1950, and that death occurred at 8:55P m., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director M. D.

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

2/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2/27/50

24C. NAME OF CEMETERY OR CREMATORY

Balto National

24D. LOCATION (City, town, or county)

Balto Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 24 1950

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

STATE OF NEW YORK

1924

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALBERT G. BOTELER

2. DATE OF DEATH
Feb. 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **5615 Fern Park Ave.**

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore, 28-02

D. STREET ADDRESS (If rural, give location)
5615 Fern Park Avenue

Length of stay in Baltimore

5. SEX
Male

6. COLOR OR RACE
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH
March 12, 1878

9. AGE (In years last birthday)
71

If Under 1 Year: Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chief Clerk

10B. KIND OF BUSINESS OR INDUSTRY
B&O. Railroad

11. BIRTHPLACE (State or foreign country)
Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
Albert Eugene Boteler

14. MOTHER'S MAIDEN NAME
Anna Clarks Streets

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.
None

17. INFORMANT ADDRESS
James Glenn Boteler 5615 Fern Park Ave

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Arteriosclerotic Heart Disease**

INTERVAL BETWEEN ONSET AND DEATH

1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma of Prostate

? months

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Insp. & Inq.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE
Russell S Fisher

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED
2-21-50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE
2-24-50

24C. NAME OF CEMETERY OR CREMATORY
Loudon Park

24D. LOCATION (City, town, or county) (State)
Balto., Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE
Ellsworth Armacost

25. FUNERAL DIRECTOR

ADDRESS

Ellsworth ARMACOST 5118 Gwynn Oak Ave.

Ellsworth Armacost 5118

VS 151
FEB 24 1950

266 470

DATE OF DEATH

2/1/1900

50 1636 BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

50 1636
 Registered No.

BIRTH NO.

1. NAME OF DECEASED
 (Type or Print)

WILLIAM STANLEY ALLEN

2. DATE
 OF
 DEATH

2/22/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

b. FULL NAME OF (If not in hospital or institution, give street address or location)
 HOSPITAL OR INSTITUTION

Maryland General Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore #16

d. STREET ADDRESS (If rural, give location)

3414 ALTO Rd

Length of stay in Baltimore

Life

Yrs.
 Mos.
 Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days
 11. Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 11, 1950, to Feb 22, 1950, that I last saw the deceased alive on Feb 22, 1950, and that death occurred at 11:50 P.m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1637
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John C. Bacon			2. DATE OF DEATH Feb. 22/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 5100 Whiteford Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-11		
Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 5100 Whiteford Ave.		
5. SEX Male	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 4, 1875	9. AGE (in years last birthday) 74	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John E. Bacon			14. MOTHER'S MAIDEN NAME Anna Shepperd		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Mary Steinetz, 5100 Whiteford Ave.		

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

II ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis

DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

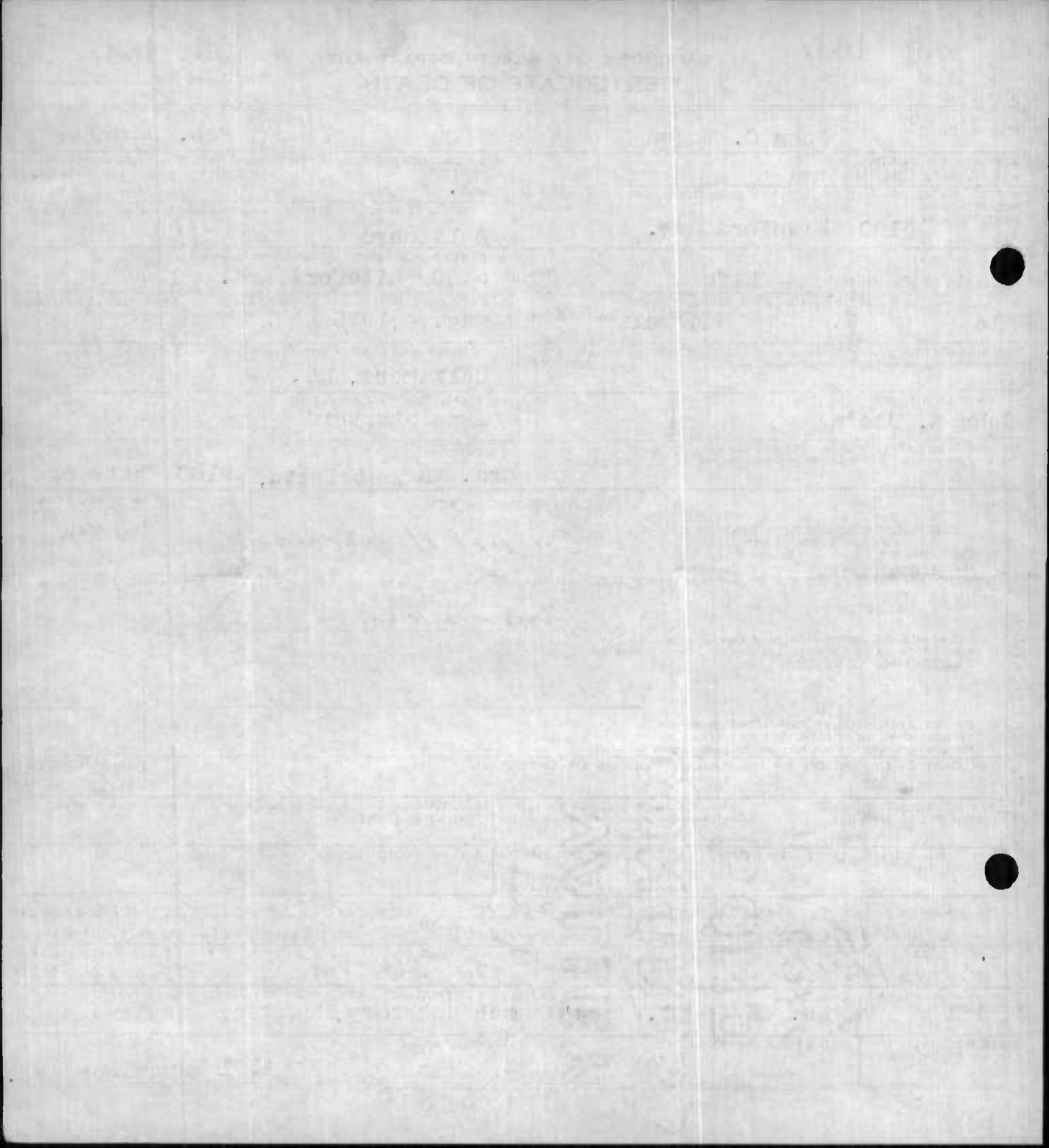
INTERVAL BETWEEN ONSET AND DEATH
1 day

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 21, 1950, to Feb. 22, 1950, that I last saw the deceased alive on Feb. 22, 1950, and that death occurred at 10:20 P. M., from the causes and on the date stated above.					
23A. SIGNATURE Harold H. Benson, M.D.		23B. ADDRESS 5111 York Rd.		23C. DATE SIGNED Feb. 24, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb. 25/50		24C. NAME OF CEMETERY OR CREMATORY St. James' Church Cemetery, Monkton, Maryland	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR William H. Berry & Son, Inc. 4101 Edmondson Ave.			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		ADDRESS	

VS 150

FEB 24 1950

50 00001639 83a



50 1638

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1638

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)C.
Frank Melzer2. DATE
OF
DEATH332
Feb. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution location)

St. Agnes Hospital

Yrs.
Mos.
Days

Length of stay in Baltimore

40

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Police man

10B. KIND OF BUSINESS OR INDUSTRY

BALTO. City

13. FATHER'S NAME

Frank C.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

md

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO.

D. STREET ADDRESS (If rural, give location)

5654 Carville Ave

8. DATE OF BIRTH

2-18-1909

9. AGE (In years last birthday)

41 40

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Cordellia Morgan

17. INFORMANT

Rosella Melzer

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Thrombosis

7 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Cerebral Atherosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Congestion

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

20. AUTOPSY?

YES ☒ NO ☐

22. I hereby certify that I attended the deceased from 12/16, 1947, to 2/23, 1950, that I last saw the deceased alive on 2/23, 1950, and that death occurred at 8:30 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Stephen K. Padonias

M. D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

2-23-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-25-50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Belle.

(State)

md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William M. Williams

25. FUNERAL DIRECTOR

Harry H. Witzke

ADDRESS

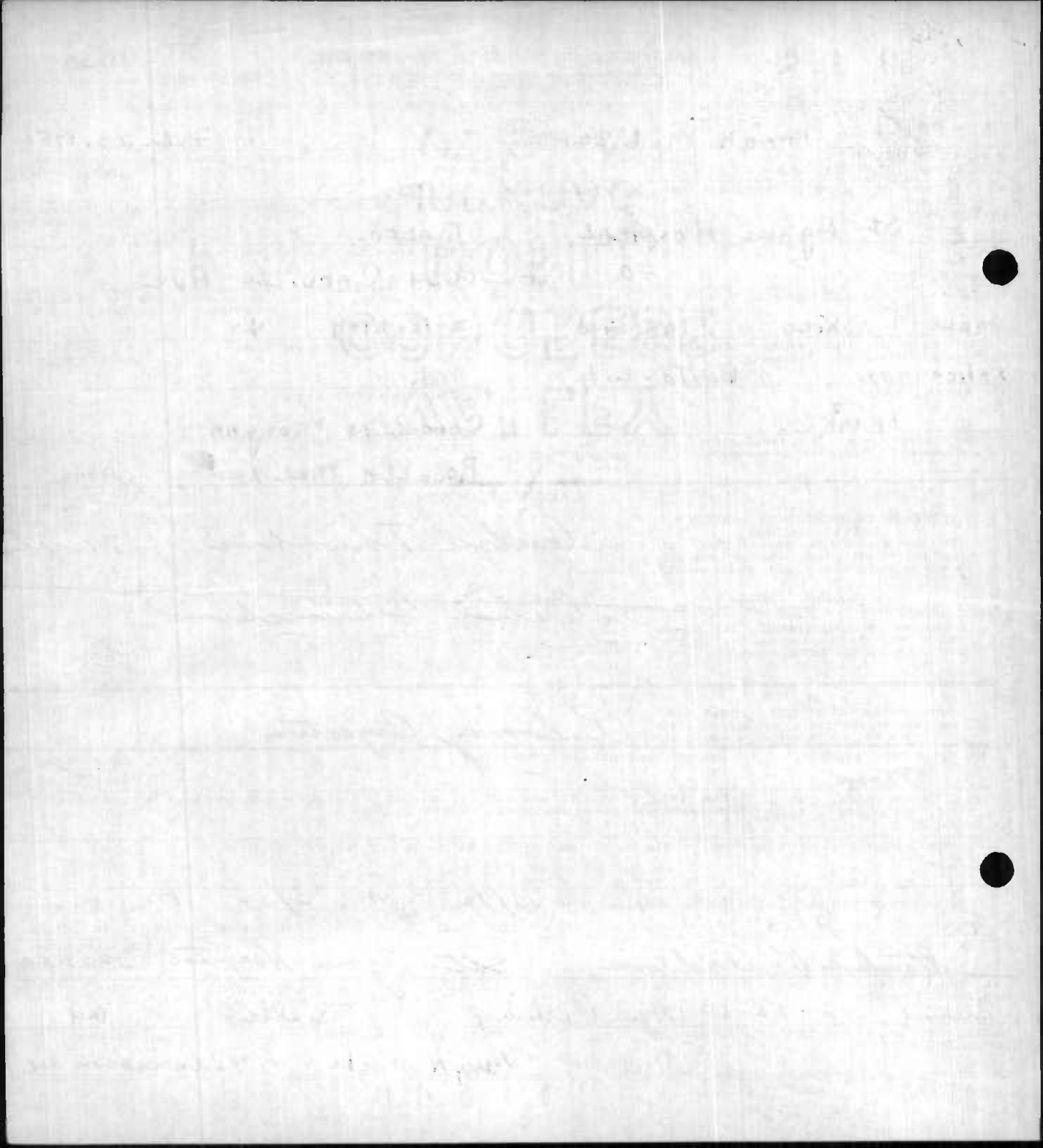
4101 Edmondson Ave

VS 150

604980 500001640

83R

correct age is expected important. Infants - please write the causes of death clearly and legibly.



200
1639BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

163 Registered No. 50 1639

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Louis Rocha</i>			2. DATE OF DEATH <i>Feb. 22, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>617 Sterling St.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 5-02</i>		
C. Length of stay in Baltimore <i>35 yrs.</i>			D. STREET ADDRESS (If rural, give location) <i>617 Sterling St.</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 18, 1886</i>	9. AGE (In years last birthday) <i>64</i>	10. Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemp. Laborer.</i>			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MARDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Helmi Rocha</i>			ADDRESS <i>617 Sterling St.</i>		

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Carcinoma of lung
DUE TO

INTERVAL BETWEEN ONSET AND DEATH
1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Nov. 18, 1949*, to *Feb. 22, 1950*, that I last saw the deceased alive on *Feb. 22, 1950*, and that death occurred at *3:12 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>R. W. McDaniel</i>	23B. ADDRESS <i>807 N. Caroline St.</i>	23C. DATE SIGNED <i>2-24-50</i>
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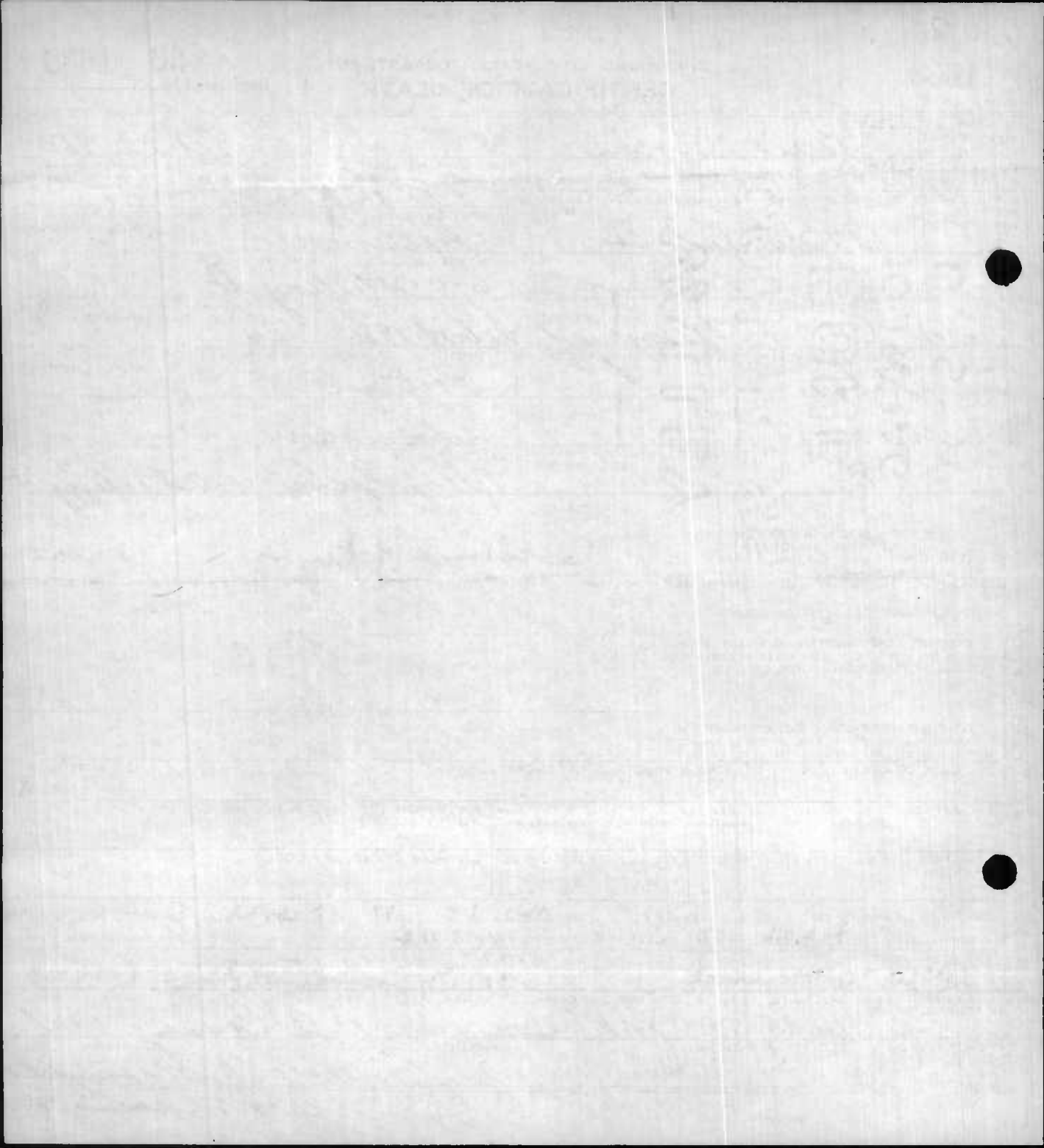
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>Feb. 25, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cemo</i>	24D. LOCATION (City, town, or county) (State) <i>A. A. County Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 25 1950</i>		REGISTRAR'S SIGNATURE <i>William M. Williams</i>	25. FUNERAL DIRECTOR <i>Mrs. Robert A. Elliott</i>

VS 150

88899

47D

1129 N. Caroline St.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1640
Registered No. 50 1640

BIRTH NO. 49-26926

1. NAME OF DECEASED (Type or Print) WILLIAM FRANCIS PRATHER		2. DATE OF DEATH February 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION 700 Fleet Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore (O'Donnell Heights)	
D. STREET ADDRESS (If rural, give location) 6213 Fortview Way		26-06	
5. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____		8. DATE OF BIRTH Dec. 7, 1949	
6. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	9. AGE (In years last birthday) 2 17
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Edwin R. Prather		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Louise Prather		ADDRESS 6213 Fortview Way	

18. 491X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Focal broncho and interstitial pneumonia		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
(B) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DISEASE OR CONDITION CAUSING IT.		
(C) DUE TO		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <u>natural causes</u> <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE N. J. McClafferty	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. _____	23C. DATE SIGNED 2-24-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb 27, 1950	24C. NAME OF CEMETERY OR CREMATORY London Park
24D. LOCATION (City, town, or county) Baltimore	24E. FUNERAL DIRECTOR W. E. 22247	
DATE RECEIVED BY LOCAL REGISTRAR FEB 25 1950	REGISTRAR'S SIGNATURE William Williams	ADDRESS 107

35090

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

33² 50 1641
 Registered No. _____

BIRTH NO. 1811

1. NAME OF DECEASED (Type or Print) Marian Schier			2. DATE OF DEATH 2-23-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore, Maryland</i>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-01		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 1324 Andre Street		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 9/11		9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Fred Herrmann			14. MOTHER'S MAIDEN NAME Rose		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cerebral arteriosclerosis DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic heart disease		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/17 , 1950, to 2/23 , 1950, that I last saw the deceased alive on 2/23 , 1950, and that death occurred at 12:15 P. m. , from the causes and on the date stated above.					
23A. SIGNATURE <i>Harry J. Depuy</i>		M. D. 1213 Light Street		23C. DATE SIGNED 2/23/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 2-25-50		24C. NAME OF CEMETERY OR CREMATORY Holy Cross	
24D. LOCATION (City, town, or county) (State) A.A. Co.		25. FUNERAL DIRECTOR ADDRESS Charles F. Hill 1501 E. Lombard			

Central Library
Chicago, Illinois

Reference to last year

John G. Johnson
Chicago, Illinois

-520
50 1642

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1642

Registered No.

1. NAME OF DECEASED (Type or Print) Pauline Manns			2. DATE OF DEATH Feb. 24, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1603 Bruce Court Apt. #2			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 15-02		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1603 N. Bruce Court Apt. #2		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 13, 1919	9. AGE (In years, last birthday) 30	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Paul Toopence			14. MOTHER'S MAIDEN NAME Edna ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mr. John Mann 1603 Bruce Court Apt 2		
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Myocardial Degeneration DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH 6 mrs 2 days
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-8 , 19 49 to 2-24 , 19 50 , that I last saw the deceased alive on 2-24 , 19 50 , and that death occurred at 1:00 A. m. , from the causes and on the date stated above.					
23. SIGNATURE John C. Williams		23B. ADDRESS 1524 3 Penna. Ave		23C. DATE SIGNED 2/25/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-27-50		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25. FUNERAL DIRECTOR (Mrs) Frances A. Hemsley		ADDRESS 578 W. Biddle St.	

DEATH CERTIFICATION

DATE RECEIVED BY LOCAL REGISTRAR
FEB 25 1950

REGISTRAR'S SIGNATURE
John C. Williams

1644 1312

MAILED
JAN 11 1964
COMM-FED

RECEIVED

NOV 11 1963

11-11-63

NOV 11 1963

NOV 11 1963

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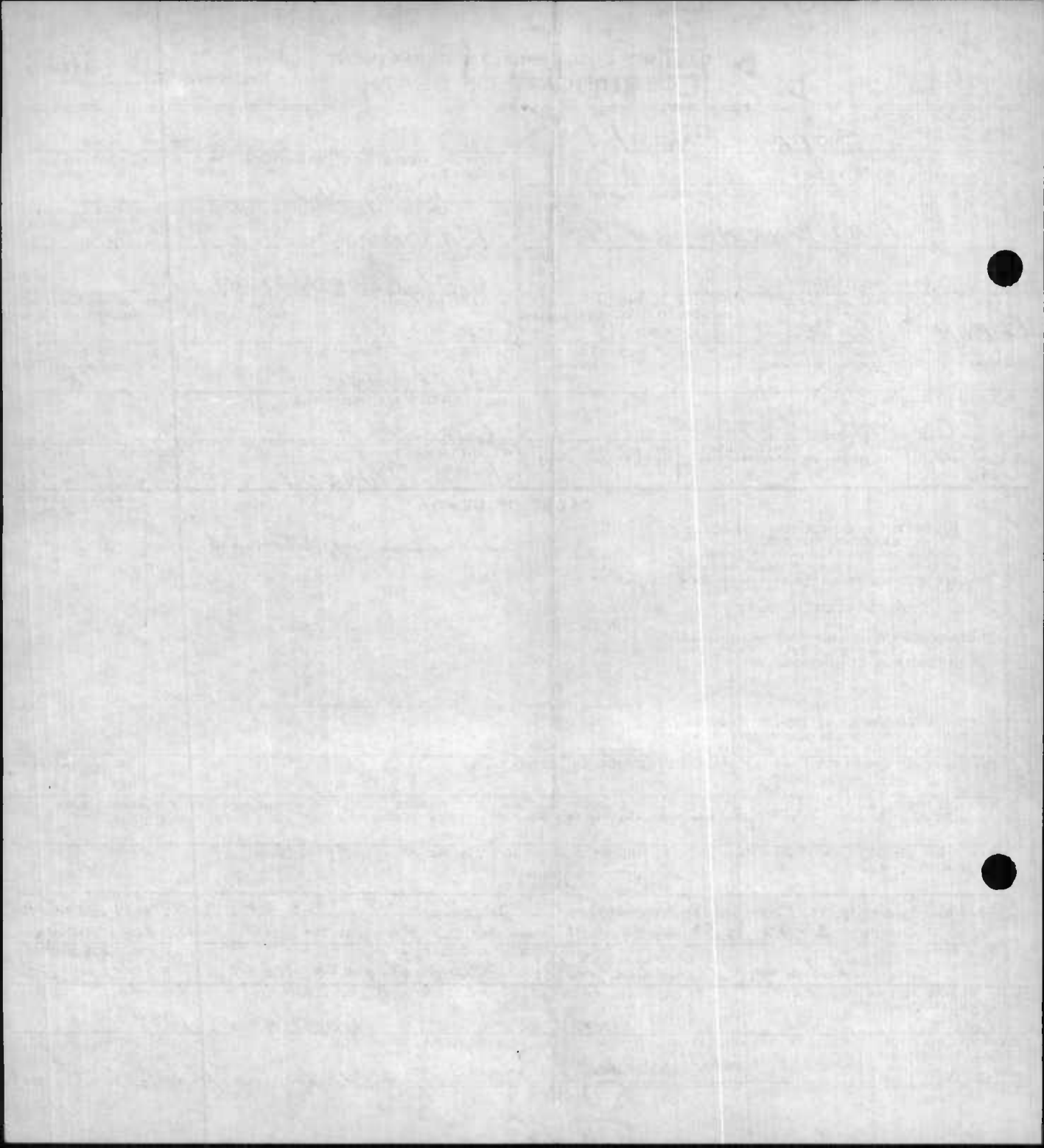
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1643

524
1643

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>SARAH ENGEL</i>		2. DATE OF DEATH <i>2-22-50</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY			
b. FULL NAME OF (If not in hospital or institution, give street address or location) <i>4721 PENNINGTON AVE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 25-05</i>			
Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <i>4721 PENNINGTON AVE</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Oct 9, 1866</i>	9. AGE (In years last birthday) <i>83</i>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Frederick Potts</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Julia Murphy 4721 Pennington Ave</i>	
18. CAUSE OF DEATH					
18a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>carcinoma of stomach</i>					
18b. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>2-3 yrs?</i>					
18c. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan</i> , 19 <i>48</i> , to <i>Feb 22</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>2-22</i> , 19 <i>50</i> , and that death occurred at <i>1 P.M.</i> , from the causes and on the date stated above.					
23a. SIGNATURE <i>Philip W. Reiter, M.D.</i>		23b. ADDRESS <i>302 Patuxent Ave</i>		23c. DATE SIGNED <i>2-24-50.</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>2-25-50</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>	
24d. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>					
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 25 1950</i>		REGISTRAR'S SIGNATURE <i>William W. Williams, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS <i>John F. Denny, Inc. 715 Light St.</i>	

MEDICAL CERTIFICATION



400

PAULL

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1644

Registered No.

BIRTH NO. 50 1644

1. NAME OF DECEASED (Type or Print) <i>Mary J. Paull</i>		2. DATE OF DEATH <i>2/24/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>4709 Park Heights Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>27-16</i>			
C. Length of stay in Baltimore <i>1 yr.</i> Yrs. Mos. Days			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>June 14/1860</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	9. AGE (In years last birthday) <i>89</i>
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>James Pritchett</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Florence Coates</i>		ADDRESS <i>4709 Park Heights</i>	

18. I	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Arterio Sclerosis</i>	<i>several</i>
ANTECEDENT CAUSES	(B) <i>Chronic Myocarditis</i>	<i>years.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) <i>Old age.</i>	
II		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Feb. 3, 1950</i> to <i>2-24, 1950</i> , that I last saw the deceased alive on <i>2-23, 1950</i> , and that death occurred at <i>1 p.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Dr. C. Blake</i>	23B. ADDRESS <i>Med Arts Bldg.</i>	23C. DATE SIGNED <i>2-25-50</i>

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <i>2/27/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>MT Olivett Park</i>	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 25 1950</i>	REGISTRAR'S SIGNATURE <i>William M. Williams</i>	25. FUNERAL DIRECTOR <i>Chas P. Towell</i>	ADDRESS <i>2427 Edmondson Ave</i>

Mr H. Blake
multicolored.

530
50 1645BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1645

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DAVID SINNOTT

2. DATE
OF
DEATH

2/23/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Balto.

9-04

D. STREET ADDRESS (If rural, give location)

3845 Green Mount Ave

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Bridgeway

10B. KIND OF BUSINESS OR
INDUSTRYSinger & Sons
Construction Co

13. FATHER'S NAME

Nicholas J. Sinnott

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

11. BIRTHPLACE (State or foreign country)

Phila Pa

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Josephine Myers

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

A

Disseminated Carcinoma

5 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

B

Carcinoma of Bladder

1 yr.?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

C

19A. DATE OF OPERATION

1/18/49, 11/15/49

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Bladder

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct '49 to Feb 23, 1950, that I last saw the
deceased alive on Feb 22, 1950, and that death occurred at 8A m., from the causes and on the date stated above.

23A. SIGNATURE

M. E. Ruben

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

2/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3/27/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Parkville Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

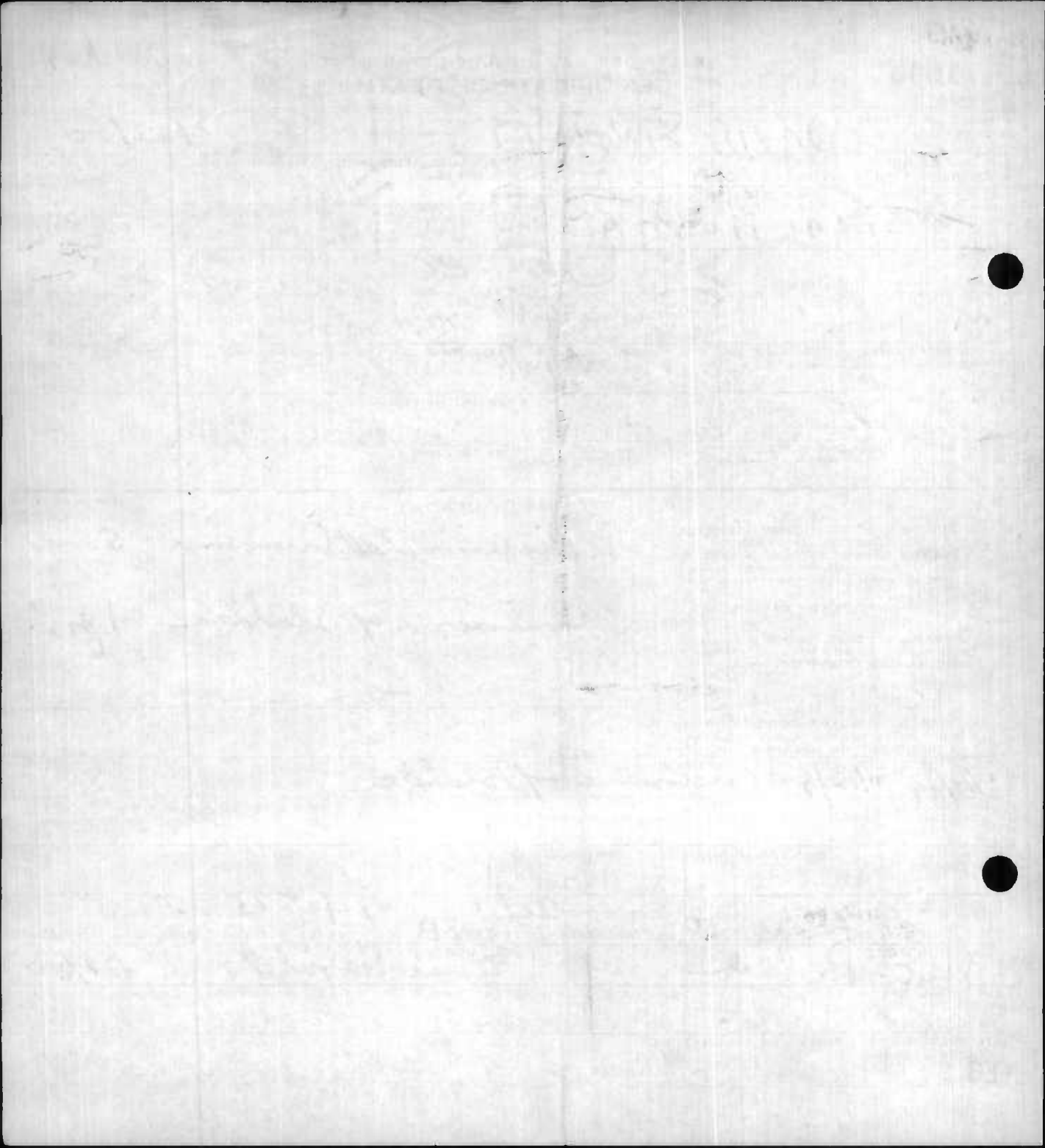
Wm Cook Inc. 1217 St. Paul St.

VS 150

306 V9

500001647

52 B



634

CERTIFICATE CORRECTED

2-27-50

BALTIMORE CITY HEALTH DEPARTMENT

50 1646

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50 1646

1. NAME OF DECEASED
(Type or Print)*Edward Oxy Barthlow*2. DATE
OF
DEATH*2/22/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION*1122 W. Lombard St*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Md 18-03

D. STREET ADDRESS (If rural, give location)

1122 W Lombard St

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Retired laborer*10B. KIND OF BUSINESS OR
INDUSTRY*Ground Markets*

11. BIRTHPLACE (State or foreign country)

*Martinsburg W. Va*12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

(Unknown) Barthlow

14. MOTHER'S MAIDEN NAME

*Unknown*15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Madeline Kaffman 941 Burgundy St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *A.C.V disease & Aortic and 4 yrs
DUE TO mitral stenosis and Insufficiency*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) _____

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 1945*, to *Feb 22, 1950* that I last saw the
deceased alive on *Feb 20, 1950*, and that death occurred at *4:00* p.m., from the causes and on the date stated above.

23A. SIGNATURE

P. J. Chulinski

M. D.

23B. ADDRESS

1945 N Balto St

23C. DATE SIGNED

*2/23/50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

2/25/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

A. A. Co. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William M. Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook, Inc. 1217 St. Paul St.

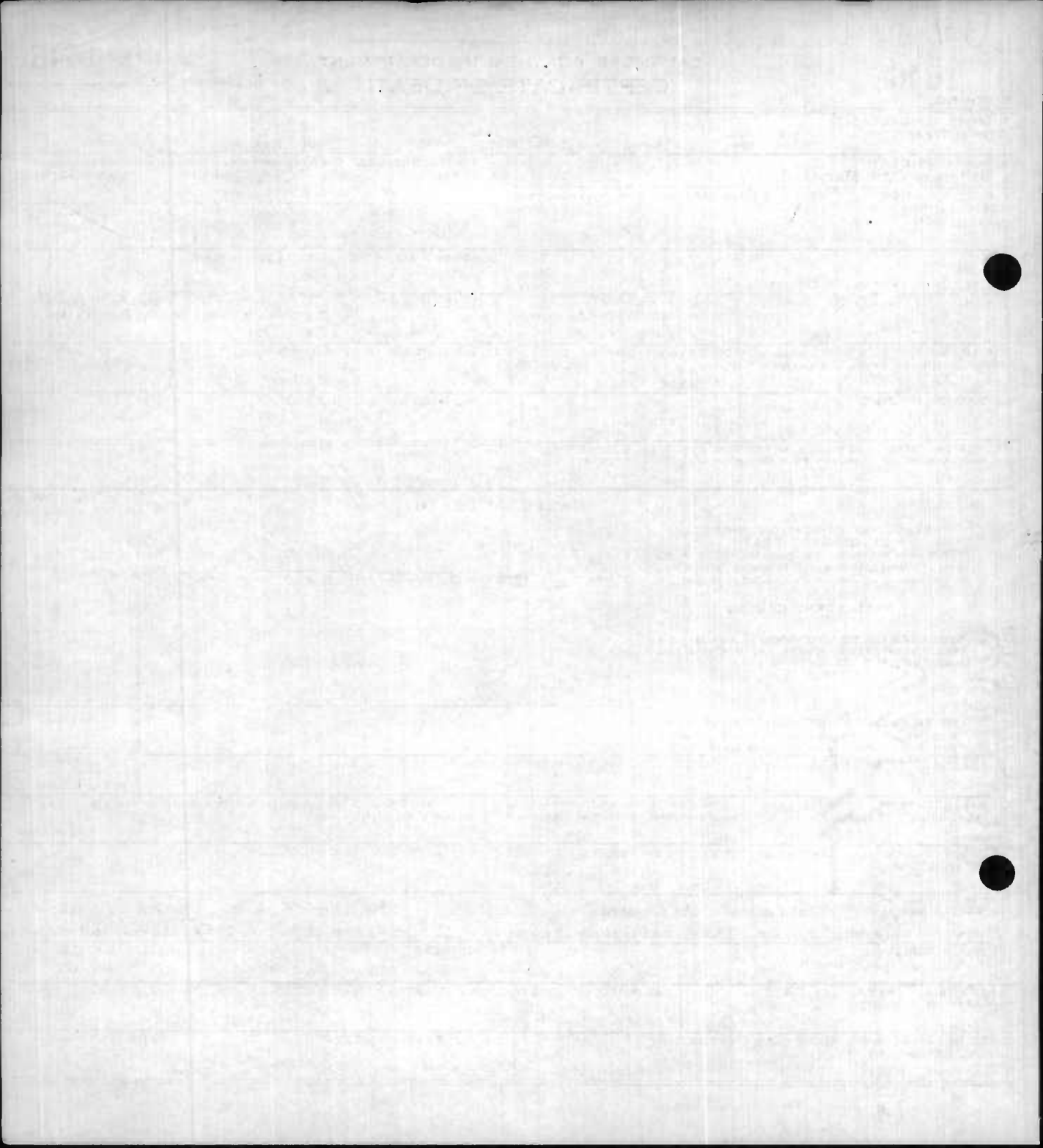
FEB 25 1950

VS 150

98861

92 B

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
 CERTIFICATE OF DEATH

Registered No.

50 1647

50 1647

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mennis Williams			2. DATE OF DEATH Feb. 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 504 Orchard St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01		
D. STREET ADDRESS (If rural, give location) 504 Orchard St.			E. LENGTH OF STAY IN BALTIMORE Unk.		
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH unk.	9. AGE (In year - last birthday) 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10B. KIND OF BUSINESS OR INDUSTRY GRAVEL CO.		
11. BIRTHPLACE (State or foreign county) unk.			12. CITIZEN OF WHAT COUNTRY? N. S. A.		
13. FATHER'S NAME unk.			14. MOTHER'S MAIDEN NAME unk.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) unk.			16. SOCIAL SECURITY NO. ?		
17. INFORMANT Roberta Wilkins - 28th St.			ADDRESS		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardio Vascular Renal Disease	INTERVAL BETWEEN ONSET AND DEATH 1 yr.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Pulmonary Edema	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb. 15, 1950**, to **Feb. 21, 1950**, that I last saw the deceased alive on **Feb. 15, 1950**, and that death occurred at **12:15 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE **[Signature]** M. D. **600 N. Arlington Ave.** 23B. ADDRESS **2-21-50** 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/25/50	24C. NAME OF CEMETERY OR CREMATORY Ellendge Md.	24D. LOCATION (City, town, or county) (State)
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DATE RECEIVED BY LOCAL REGISTRAR FEB 25 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR W. Halstead - 918 -	ADDRESS Almid Hill Ave.
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WALKER
CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

413

Talbott

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1648

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Talbott

2. DATE
OF
DEATH

Feb. 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1623-N. Gilman St.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)4. USUAL RESIDENCE (Where deceased lived, if institution; residence
A. STATE B. COUNTY before admission)

Md.

City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-01

D. STREET ADDRESS (If rural, give location)

1623-Gilman St.

C. Length of stay in Baltimore

10 Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Sparking Plant

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

no

16. SOCIAL
SECURITY NO.

no

14. MOTHER'S MAIDEN NAME

Sallie Ann

17. INFORMANT

James Johnson - Gilman St

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Cerebral Hemorrhage -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Generalized Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Rheumatoid Arthritis

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on _____, 19____, and that death occurred at 12:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Ann H. Carter, Jr.

23B. ADDRESS

1845 Pennsylvania Ave

23C. DATE SIGNED

2/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2/25/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county) (State)

Adams Hill

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Wm. H. H. H. H. H.

ADDRESS

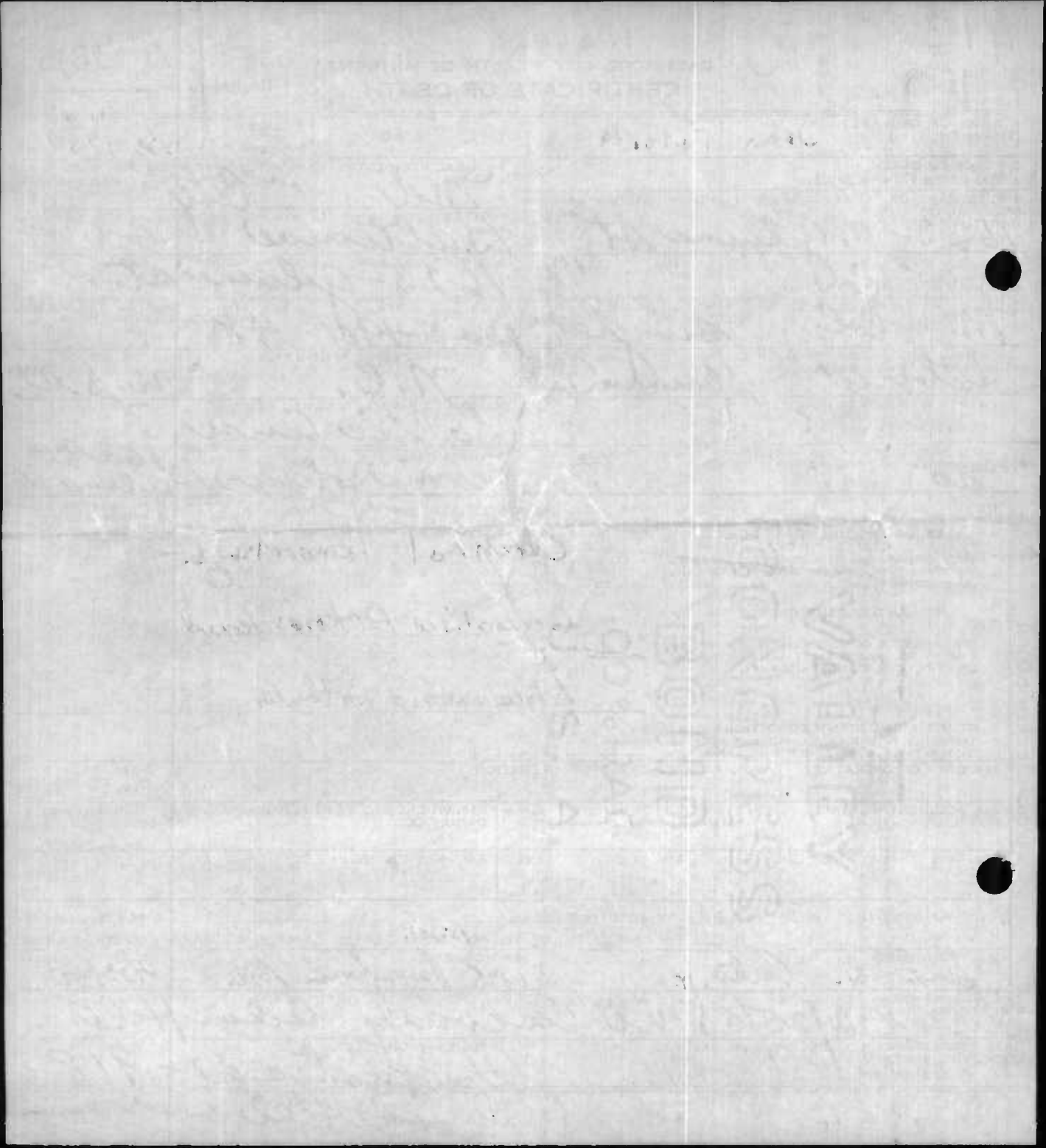
918-

VS 150

98A4V

83a Union Hill Ave

MEDICAL CERTIFICATION



120

CERTIFICATE CORRECTED 1-10-50

BALTIMORE CITY HEALTH DEPARTMENT

50 1649

CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 1649

1. NAME OF DECEASED (Type or Print) ERNEST DAVIS		2. DATE OF DEATH February 22, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-02	
D. STREET ADDRESS (If rural, give location) 1022 Shields Place		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Dec. 25/1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10B. KIND OF BUSINESS OR INDUSTRY Railroad	
13. FATHER'S NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) no none		16. SOCIAL SECURITY NO. 577-10-962	
11. BIRTHPLACE (State and foreign country) S. C.		14. MOTHER'S MAIDEN NAME Emma Richardson	
17. INFORMANT Mary E. Jones - 1513 N. Grand St. Phil. Pa.			

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Ascites ? Cirrhosis of liver		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry and Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE R S Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Feb. 22, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/25/50		24C. NAME OF CEMETERY OR CREMATORY Ant. Calvary	
24D. LOCATION (City, town, or county) (State) Cedar Hill Md.		25. FUNERAL DIRECTOR A. Halstead - 918 -		ADDRESS Union Hill Ave	

VS 151 44247

12412

Union Hill Ave ✓

correct age is especially important. In some cases, please print full name of child, if any, and date of birth.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Signature of physician		8. Signature of registrar	
9. Name of informant		10. Address of informant		11. Date of registration		12. Registrar's office	
13. Name of funeral home		14. Address of funeral home		15. Date of burial		16. Burial place	
17. Name of cemetery		18. Address of cemetery		19. Date of interment		20. Interment place	
21. Name of church		22. Address of church		23. Date of service		24. Service place	
25. Name of minister		26. Address of minister		27. Date of service		28. Service place	
29. Name of sexton		30. Address of sexton		31. Date of service		32. Service place	
33. Name of undertaker		34. Address of undertaker		35. Date of service		36. Service place	
37. Name of casket		38. Address of casket		39. Date of service		40. Service place	
41. Name of coffin		42. Address of coffin		43. Date of service		44. Service place	
45. Name of shroud		46. Address of shroud		47. Date of service		48. Service place	
49. Name of pall		50. Address of pall		51. Date of service		52. Service place	
53. Name of hearse		54. Address of hearse		55. Date of service		56. Service place	
57. Name of funeral home		58. Address of funeral home		59. Date of service		60. Service place	
61. Name of cemetery		62. Address of cemetery		63. Date of service		64. Service place	
65. Name of church		66. Address of church		67. Date of service		68. Service place	
69. Name of minister		70. Address of minister		71. Date of service		72. Service place	
73. Name of sexton		74. Address of sexton		75. Date of service		76. Service place	
77. Name of undertaker		78. Address of undertaker		79. Date of service		80. Service place	
81. Name of casket		82. Address of casket		83. Date of service		84. Service place	
85. Name of coffin		86. Address of coffin		87. Date of service		88. Service place	
89. Name of shroud		90. Address of shroud		91. Date of service		92. Service place	
93. Name of pall		94. Address of pall		95. Date of service		96. Service place	
97. Name of hearse		98. Address of hearse		99. Date of service		100. Service place	

200
1650

Charley Lewis

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1650

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Charley Lewis</i>			2. DATE OF DEATH <i>2/23-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>14-02</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>1422 Division St.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
C. Length of stay in Baltimore <i>3 yrs.</i>			D. STREET ADDRESS (If rural, give location) <i>DIVISION ST</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Sept. 1891</i>	9. AGE (In years last birthday) <i>39</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self employed</i>	11. BIRTHPLACE (State or foreign country) <i>Whitcomb Village, N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Willie Lewis 1422 Division St.</i>		

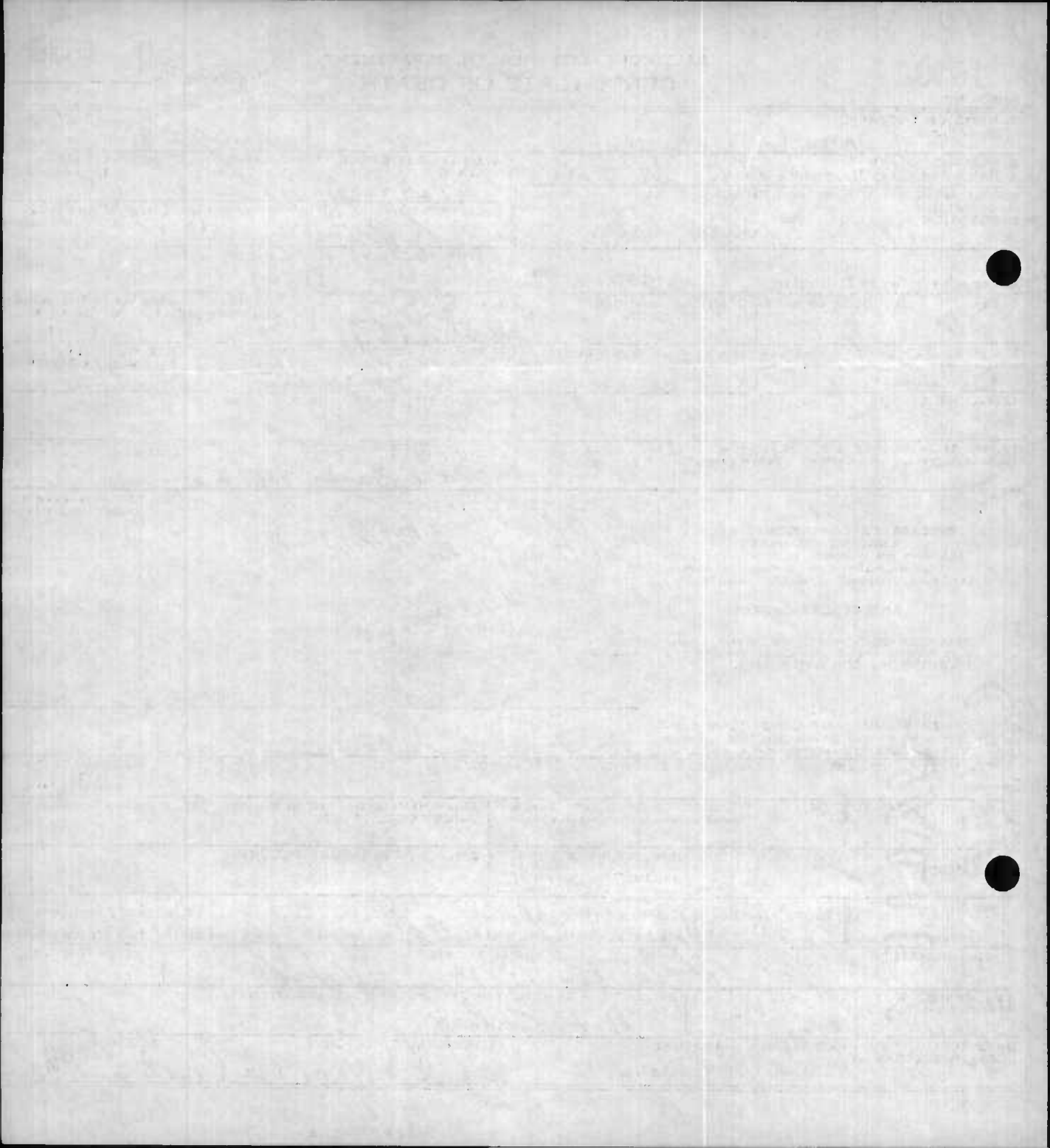
18.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Chs. Nephritis & Uremia</i>	
ANTECEDENT CAUSES		(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *1/1* to *2/23*, 19*50*, that I last saw the deceased alive on *2/22*, 19*50*, and that death occurred at *2:00* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Willie Lewis</i>	23B. ADDRESS <i>1422 Division St.</i>	23C. DATE SIGNED
------------------------------------	---------------------------------------	------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2/25/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>W.H. Calvary</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 25 1950</i>	REGISTRAR'S SIGNATURE <i>William Williams</i>	25. FUNERAL DIRECTOR ADDRESS <i>Geo. S. Nelson 1303 Presstman St.</i>	



250

CERTIFICATE CORRECTED 3-1-50

BALTIMORE CITY HEALTH DEPARTMENT

50 1651

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MELVIN ROY MASON

2. DATE
OF DEATH

Feb. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

1318 E. 36th. Street

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1318 E. 36th. Street

6. Length of stay in Baltimore

2 yrs

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

Feb. 9, 1878

9. AGE (In years last birthday)

72

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Roofing Co.

11. BIRTHPLACE (State or foreign country)

Illinois

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Lewis Mason

14. MOTHER'S MAIDEN NAME

? Neff

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

585-47-185

17. INFORMANT 1318 E. 36th. Street
Mr. Stanley Pawelek

18.

478-09-4401
478-09-4401

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Uremia

DUE TO

3 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis

DUE TO

?

(C)

Chronic Myocarditis

10 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1946 to Feb 24, 1950, that I last saw the deceased alive on Feb 23, 1950 and that death occurred at 6:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

James E. Peterman

23B. ADDRESS

M. D. 1733 E. 35th St - 18

23C. DATE SIGNED

2/24/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

2/28/50

24C. NAME OF CEMETERY OR CREMATORY

Radcliffe Cem

24D. LOCATION (City, town, or county)

Radcliffe, Iowa

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Phyllis J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

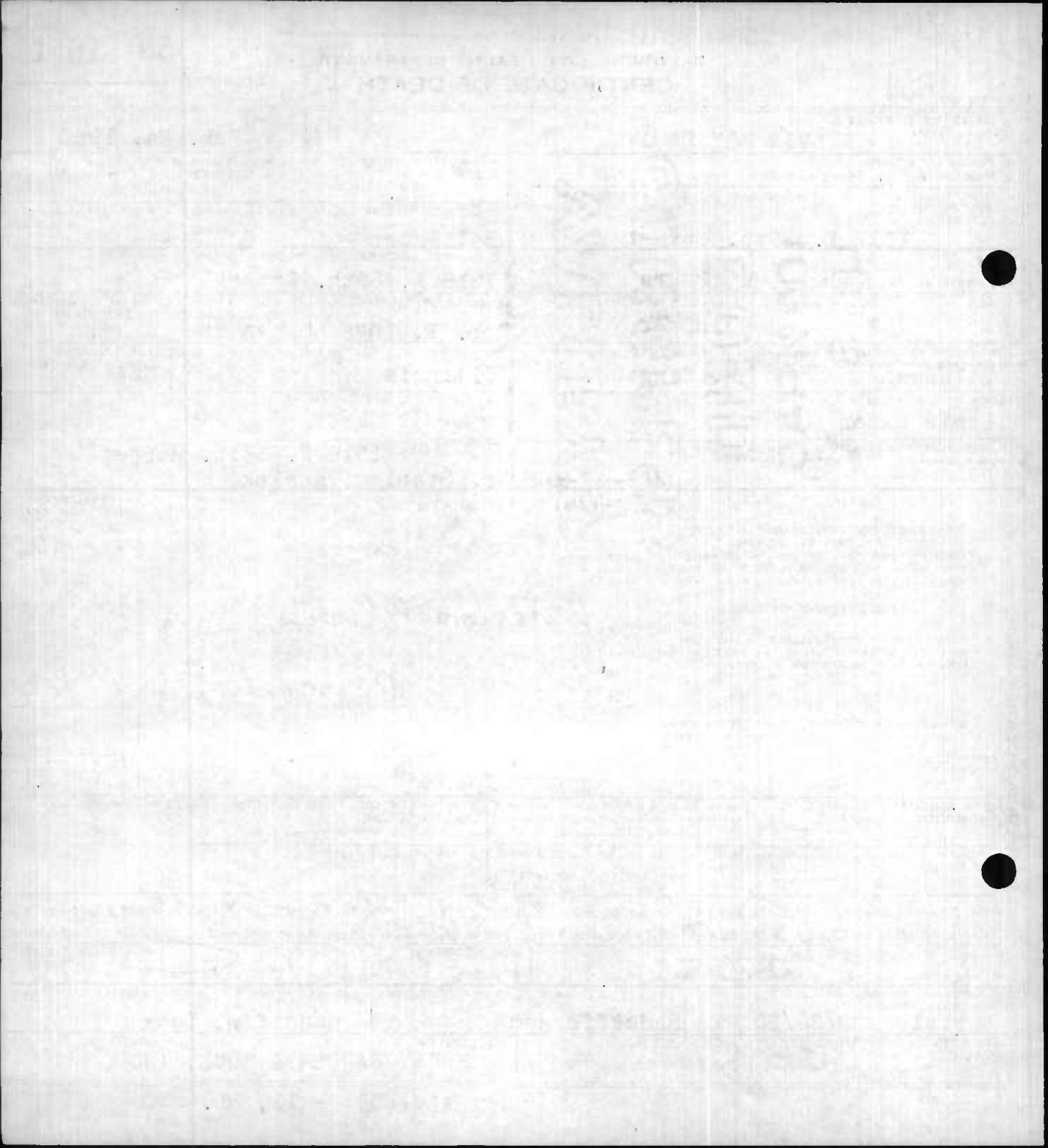
HENRY SANDER & SONS, INC

VS 150

BALTIMORE - 13, MD.

93D

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 1652

BIRTH NO. 50 1652

1. NAME OF DECEASED (Type or Print) LESLIE STEWART WILSON			2. DATE OF DEATH 2/24/50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD. B. COUNTY BALT. CITY		
B. FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL			C. CITY OR TOWN BALTIMORE		
C. Length of stay in Baltimore LIFE			D. STREET ADDRESS (If rural, give location) 3337 N. CHARLES ST. AND 39TH ST. Cambridge Arms Apts.		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH OCT. 18, 1894	9. AGE (In years, last birthday) 55	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive			10B. KIND OF BUSINESS OR INDUSTRY Insurance		
13. FATHER'S NAME ALEXANDER, WILSON			14. MOTHER'S MAIDEN NAME LAURAE RAY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Mary M. Wilson			ADDRESS Cambridge Arms Apts		

MEDICAL CERTIFICATION

<p>18. CAUSE OF DEATH</p> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>(A) CEREBRAL EMBOLISM</p> <p>DUE TO</p> <p>ANTECEDENT CAUSES</p> <p>(B) RHEUMATIC HEART DISEASE</p> <p>DUE TO</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p>(C) CONGESTIVE CARDIAC FAILURE</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>3 DAYS</p>
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-20, 1950**, to **2-24, 1950**, that I last saw the deceased alive on **2-24, 1950**, and that death occurred at **11:30 A.M.**, from the causes and on the date stated above.

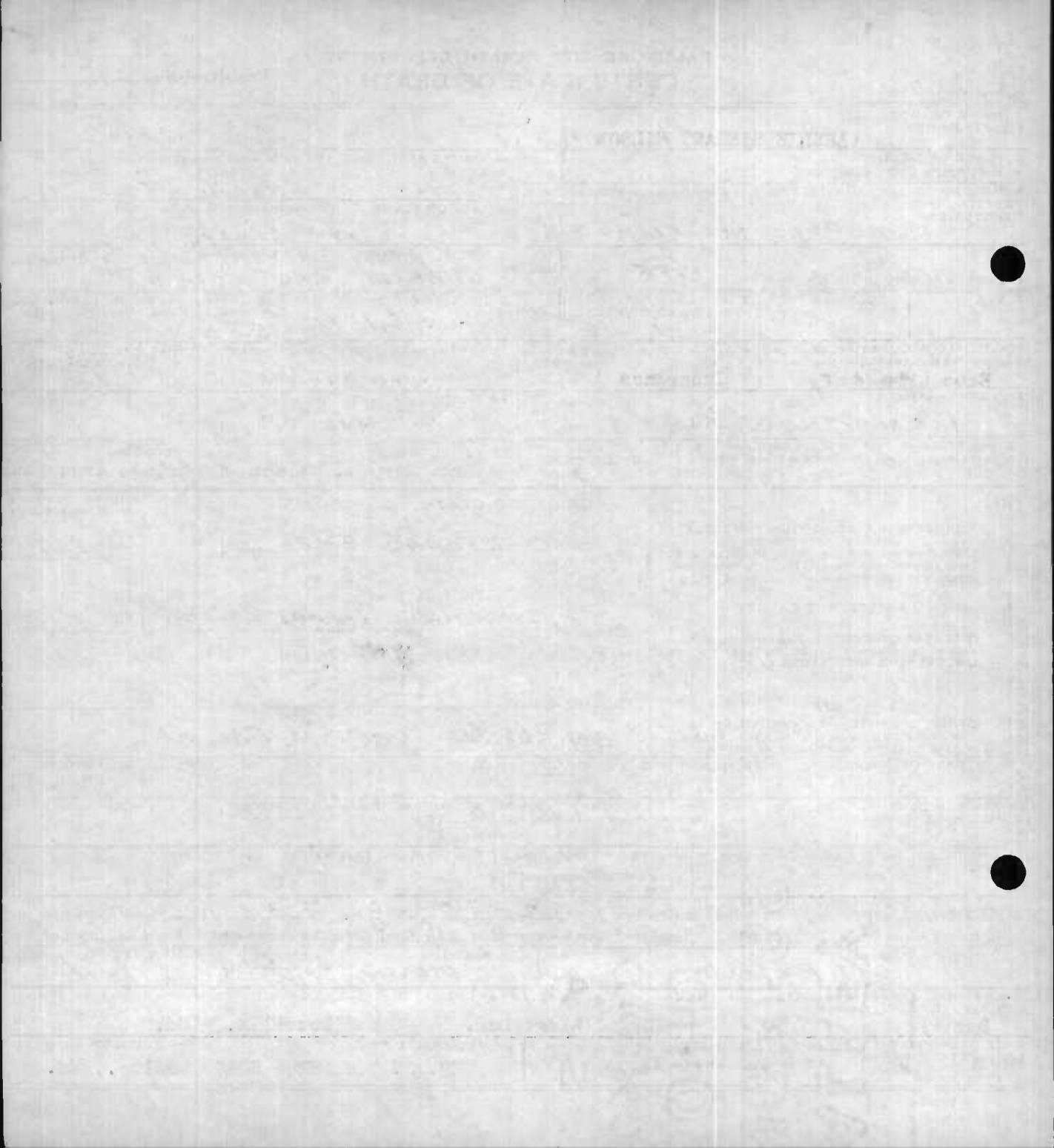
23A. SIGNATURE **Dr. Robert** M. D. 23B. ADDRESS **Mercy Hospital** 23C. DATE SIGNED **2/24/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/27/50	24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	24D. LOCATION (City, town, or county) (State) Pikesville, Md.
DATE RECEIVED BY LOCAL REGISTRAR FEB 25 1950	REGISTRAR'S SIGNATURE William M.	25. FUNERAL DIRECTOR WM. J. TICKNER & SONS	ADDRESS Balto., Md.

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520
50 1653BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1653

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD JAMES		2. DATE OF DEATH FEB. 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Md. General Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) MARYLAND GENERAL Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-19	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 2504 Manhattan ave.	
5. SEX MALE	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH May 5, 1863
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 86
13. FATHER'S NAME Thomas James		11. BIRTHPLACE (State or foreign country) Virginia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Margaret B. Smith	
17. INFORMANT		ADDRESS	

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Diverticulitis of colon	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH 30 yrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Left Ventricular Failure	(A) DUE TO (B) DUE TO (C)	

19A. DATE OF OPERATION None		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 6 , 19 50 , to Feb 24 , 19 50 , that I last saw the deceased alive on FEB. 24 , 19 50 , and that death occurred at 1 P. m. , from the causes and on the date stated above.					
23A. SIGNATURE M. D.		23B. ADDRESS Maryland Gen. Hospital		23C. DATE SIGNED 2/24/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/27/50		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	
				24D. LOCATION (City, town, or county) (State) Pikesville, Md.	

DATE RECEIVED BY LOCAL REGISTRAR FEB 25 1950		REGISTRAR'S SIGNATURE Wm. J. Tickner & Sons		25. FUNERAL DIRECTOR ADDRESS WM. J. TICKNER & SONS Balto., Md.	
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VS 150

107-500001655

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155
50 1655BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443

50 1655

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

BERT A. LOVEMAN

2. DATE
OF
DEATH

Feb. 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Alhambra Apts.

Lake Drive

C. Length of stay in Baltimore

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

13-01

D. STREET ADDRESS (If rural, give location)

Alhambra Apts., Lake Drive

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov. 16, 1876

9. AGE (In years
last birthday)

73

10. Under 1 Year
Months: Days
11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

salesman

10B. KIND OF BUSINESS OR
INDUSTRY

Textile

11. BIRTHPLACE (State or foreign country)

Dalton, Ga.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

-

14. MOTHER'S MAIDEN NAME

-

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Minnie M. Loveman Apt. 1 H-Alhambra Apt

ADDRESS
Lake Drive

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral hemorrhage

5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Cerebral arteriosclerosis

8 years

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Hypertensive cardiovascular disease

15-18 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)22. TIME (Month) (Day) (Year) (Hour)
OF INJURY

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from September, 1949, to Feb. 25, 1950, that I last saw the
deceased alive on Feb. 24, 1950, and that death occurred at 7:15 A. m., from the causes and on the date stated above.

23A. SIGNATURE

Herbert J. Gundersheimer, Jr.

M. O.

23B. ADDRESS

Riviera Apts. Lake Drive

23C. DATE SIGNED

Feb. 25, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

2.26.50

24C. NAME OF CEMETERY OR CREMATORY

Westview Cem.

24D. LOCATION (City, town, or county)

Atlanta, Ga.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER & SONS Balto. Md.

FEB 25 1950

VS 150

27405

937

CERTIFICATE OF DEATH

<p>1. Name of Deceased</p>		<p>2. Sex</p>		<p>3. Race</p>		<p>4. Date of Birth</p>		<p>5. Date of Death</p>	
<p>6. Place of Birth</p>		<p>7. Usual Residence</p>		<p>8. Cause of Death</p>		<p>9. Manner of Death</p>		<p>10. Signature of Registrar</p>	
<p>11. Signature of Physician</p>		<p>12. Signature of Coroner</p>		<p>13. Signature of Medical Examiner</p>		<p>14. Signature of Health Officer</p>		<p>15. Signature of Funeral Home</p>	
<p>16. Signature of Burial Place</p>		<p>17. Signature of Cemetery</p>		<p>18. Signature of Interment</p>		<p>19. Signature of Burial</p>		<p>20. Signature of Burial</p>	

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1656

BIRTH NO. 1656

1. NAME OF DECEASED (Type or Print) HARRY LEE		2. DATE OF DEATH February 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-05	
D. STREET ADDRESS (If rural, give location) 1633 Jefferson Street		5. LENGTH OF STAY IN BALTIMORE 10 Yrs.	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH May-22-1882
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9B. KIND OF BUSINESS OR INDUSTRY On Farm	9. AGE (In years last birthday) 67
10. FATHER'S NAME William Henry		11. BIRTHPLACE (State or foreign country) Middle River Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME Mary E. Underwood	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		15. SOCIAL SECURITY NO.	
16. INFORMANT Henry William Middle River Md		ADDRESS	

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Arteriosclerotic cardiovascular disease**

DUE TO

ANTECEDENT CAUSES

II
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐23C. DATE SIGNED
Feb. 24, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

2/27/195024C. NAME OF CEMETERY OR CREMATORY
Lorley Cem.24D. LOCATION (City, town, or county) (State)
Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

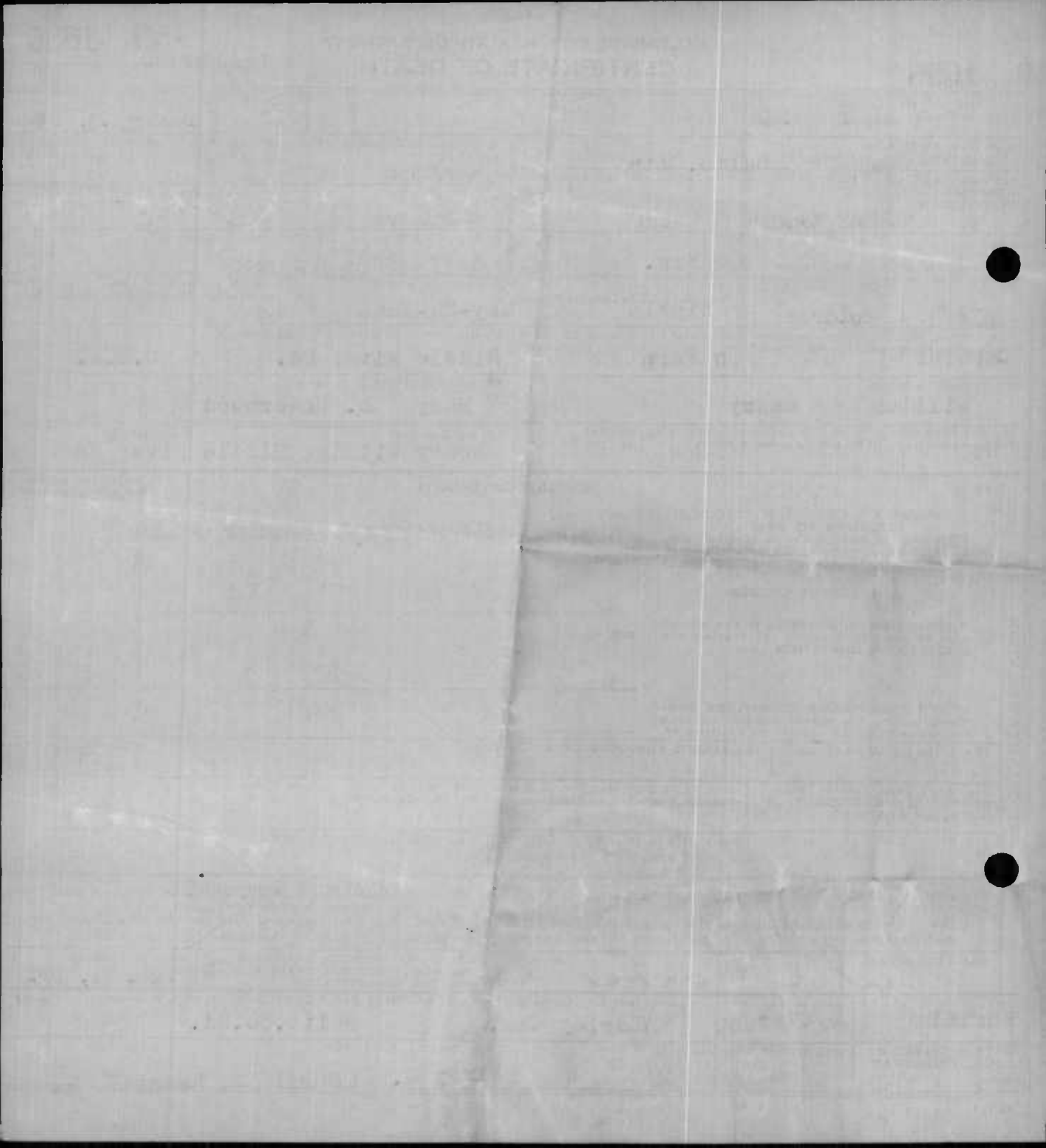
FEB 25 1950

VS 151

Elroy O. Wilson 1000 Brantly Ave

866VV

93D



S-530
50 1657BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 1657
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLEY E SMITH

2. DATE
OF
DEATH

2/24/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland University Hospital

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Woodlawn

D. STREET ADDRESS (If rural, give location)

7303 Windsor Mill Road

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

3-28-1899

9. AGE (In years
last birthday)

50

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

232-16-5717

17. INFORMANT

ADDRESS

Charles C. Smith, Woodlawn, Md

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Ventricular Fibrillation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Myocardial Infarction

DUE TO

(C) Hypertensive Cardio-Vase Disease

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 2/24, 1950, to 2/24, 1950, that I last saw the
deceased alive on 2/24, 1950, and that death occurred at 11:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

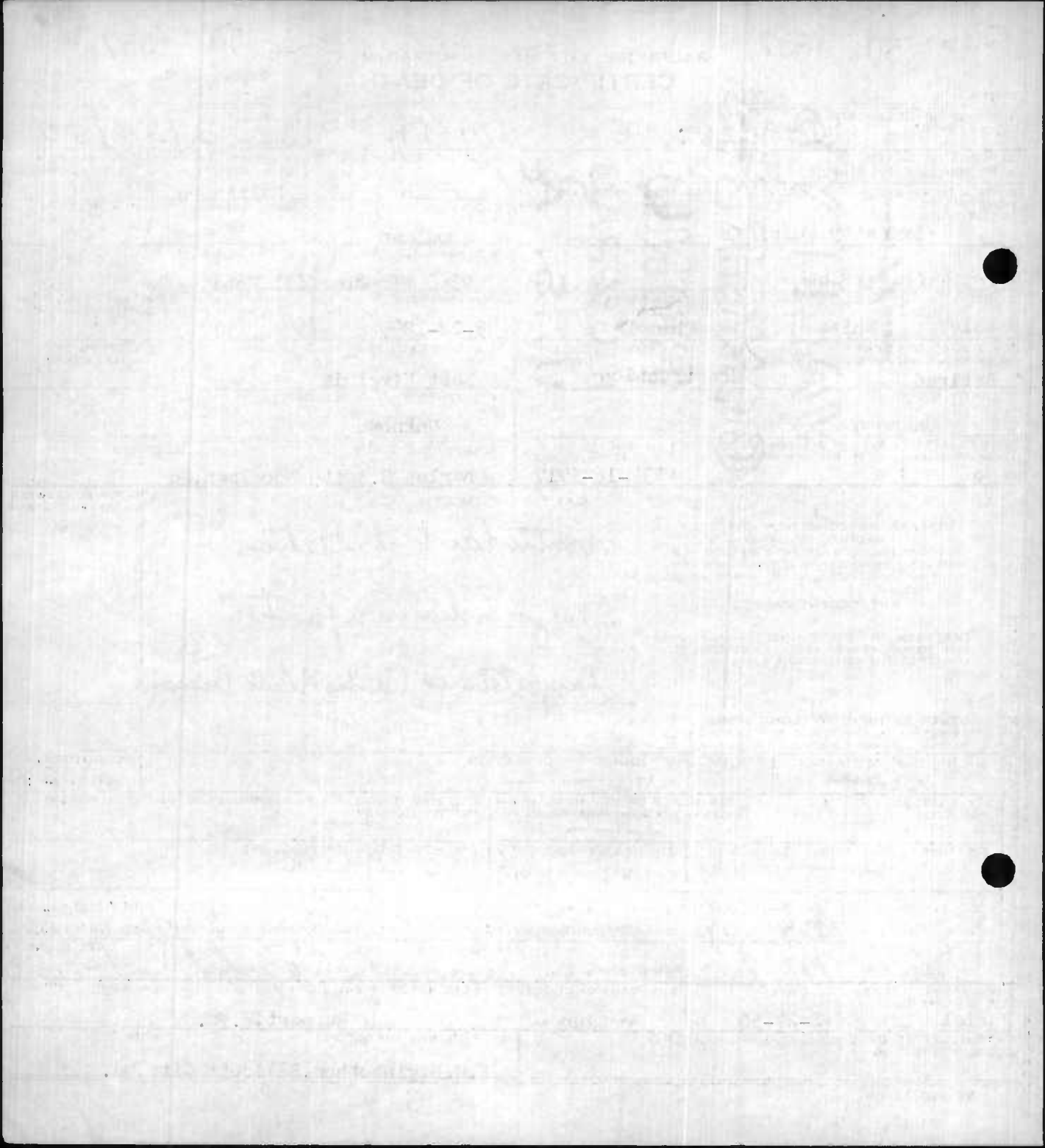
ADDRESS

F. C. Higinbotham, Ellicott City, Md.

FEB 25 1950

988 V 91 4500001659 937

MEDICAL CERTIFICATION



W-200

50 1658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 1658

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

G. Stewart Wise

2. DATE
OF
DEATH

Feb. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 113 Hawthorne Road

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

none

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

none

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

113 Hawthorne Road

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July , 1872

9. AGE (In years,
last birthday)

77

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Executive

10B. KIND OF BUSINESS OR
INDUSTRYPres., Terminal
Shipping Company

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

George Douglas Wise

14. MOTHER'S MAIDEN NAME

Lecretia Duvall Wise

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

George D. Wise - 1570 Pentwood Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) *Heart failure*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *General arteriosclerosis*
DUE TOOTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK22. I hereby certify that I attended the deceased from Feb 11, 1950, to Feb 24, 1950 that I last saw the
deceased alive on Feb 24, 1950, and that death occurred at 8:30 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Walter B. Buck M. O.

23B. ADDRESS

2 Merryman Court

23C. DATE SIGNED

2 - 25 - 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

2 - 27 - 50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell & Sons, Inc., 1900 Eutaw Pl.

FEB 25 1950

15651

Walter B. Mitchell

Dr. Walter B. Buck

10612

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]

2. Date of Birth: [illegible]

3. Sex: [illegible]

4. Race: [illegible]

5. Date of Death: [illegible]

6. Place of Death: [illegible]

7. Cause of Death: [illegible]

8. Signature of Physician: [illegible]

9. Signature of Registrar: [illegible]

10. Date of Registration: [illegible]

11. Name of Informant: [illegible]

12. Address of Informant: [illegible]

13. Signature of Informant: [illegible]

14. Date of Signature: [illegible]

15. Signature of Registrar: [illegible]

16. Date of Registration: [illegible]

17. Signature of Registrar: [illegible]

18. Date of Registration: [illegible]

19. Signature of Registrar: [illegible]

20. Date of Registration: [illegible]

21. Signature of Registrar: [illegible]

22. Date of Registration: [illegible]

23. Signature of Registrar: [illegible]

24. Date of Registration: [illegible]

25. Signature of Registrar: [illegible]

26. Date of Registration: [illegible]

27. Signature of Registrar: [illegible]

28. Date of Registration: [illegible]

29. Signature of Registrar: [illegible]

30. Date of Registration: [illegible]

31. Signature of Registrar: [illegible]

32. Date of Registration: [illegible]

33. Signature of Registrar: [illegible]

34. Date of Registration: [illegible]

35. Signature of Registrar: [illegible]

36. Date of Registration: [illegible]

50 1659

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 1659
Registered No.

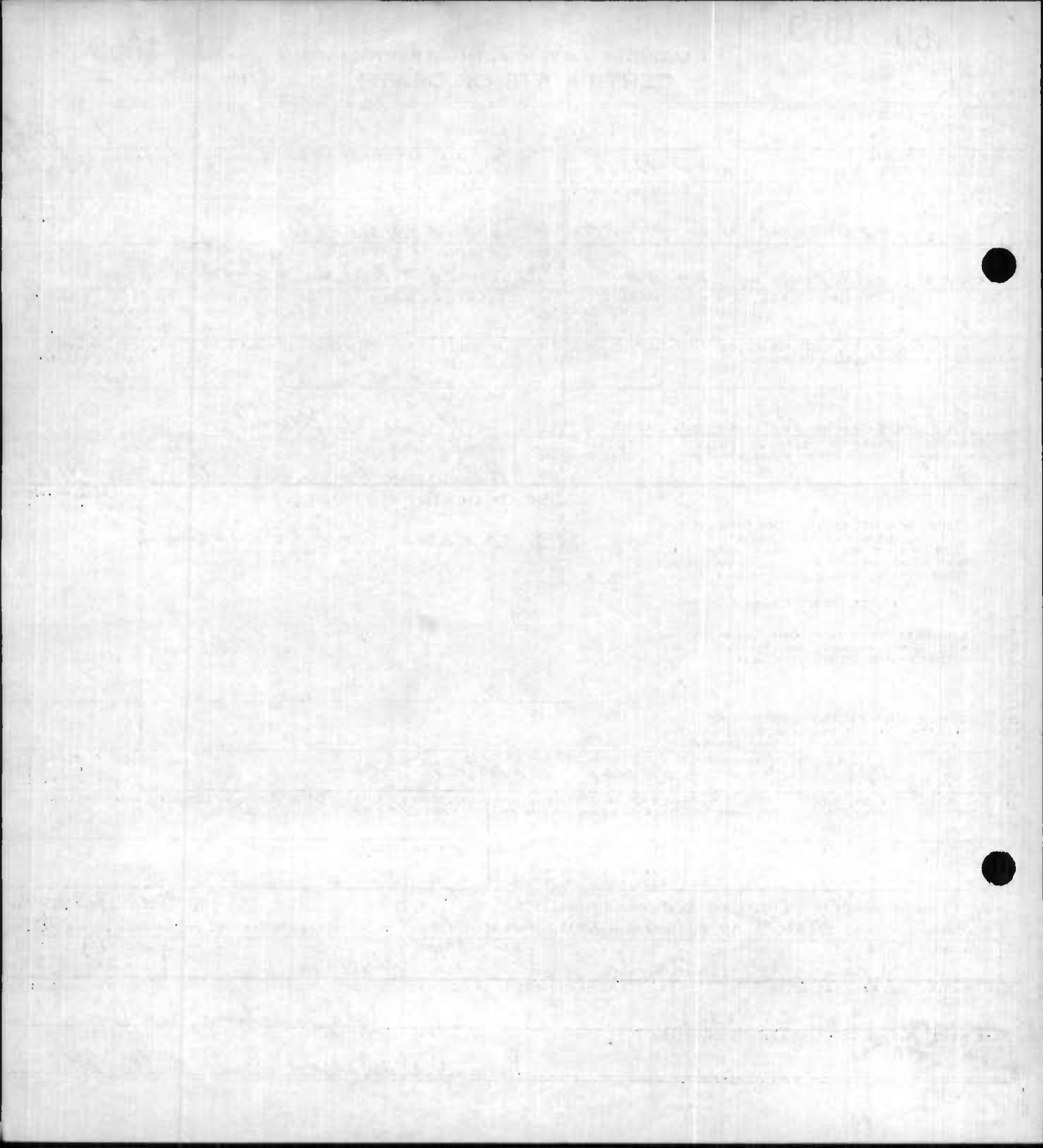
BIRTH NO.

1. NAME OF DECEASED (Type or Print) RODNEY ROBINSON			2. DATE OF DEATH 2-24-1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland UNIV. HOSP			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE W. VA. B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) UNIVERSITY OF MD. HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) SHINNASTON		
D. STREET ADDRESS (If rural, give location) 1019 Cant Ave			E. LENGTH OF STAY IN BALTIMORE 19 DAYS		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) W. Va.		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME R. Dugan Robinson			14. MOTHER'S MAIDEN NAME Karen Karl		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) N/O			16. SOCIAL SECURITY NO.		
17. INFORMANT R. Dugan Robinson			ADDRESS Shinnaston, W. Va.		

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) EXTERNAL HYDROCEPHALUS		
DUE TO		
ANTECEDENT CAUSES (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 2-8-50	19B. MAJOR FINDINGS OF OPERATION EXTERNAL HYDROCEPHALUS	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-6-50**, 1950, to **2-24**, 1950, that I last saw the deceased alive on **10:30 PM 2-24**, 1950, and that death occurred at **10 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE John W. Stover	23B. ADDRESS UNIV. HOSP	23C. DATE SIGNED 2-25-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 2-25-1950	24C. NAME OF CEMETERY OR CREMATORY Shinnaston, W. Va.
24D. LOCATION (City, town, or county) (State) Shinnaston, W. Va.	25. FUNERAL DIRECTOR Raymond J. Trubner + Son	ADDRESS Balto, Md.
DATE RECEIVED BY LOCAL REGISTRAR 2-26-1950	REGISTRAR'S SIGNATURE Wm. J. Williams	



0-54050 1660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

002 50 1660

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 8, 1950, to Feb 24, 1950, that I last saw the deceased alive on Feb. 23, 1950, and that death occurred at 11 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

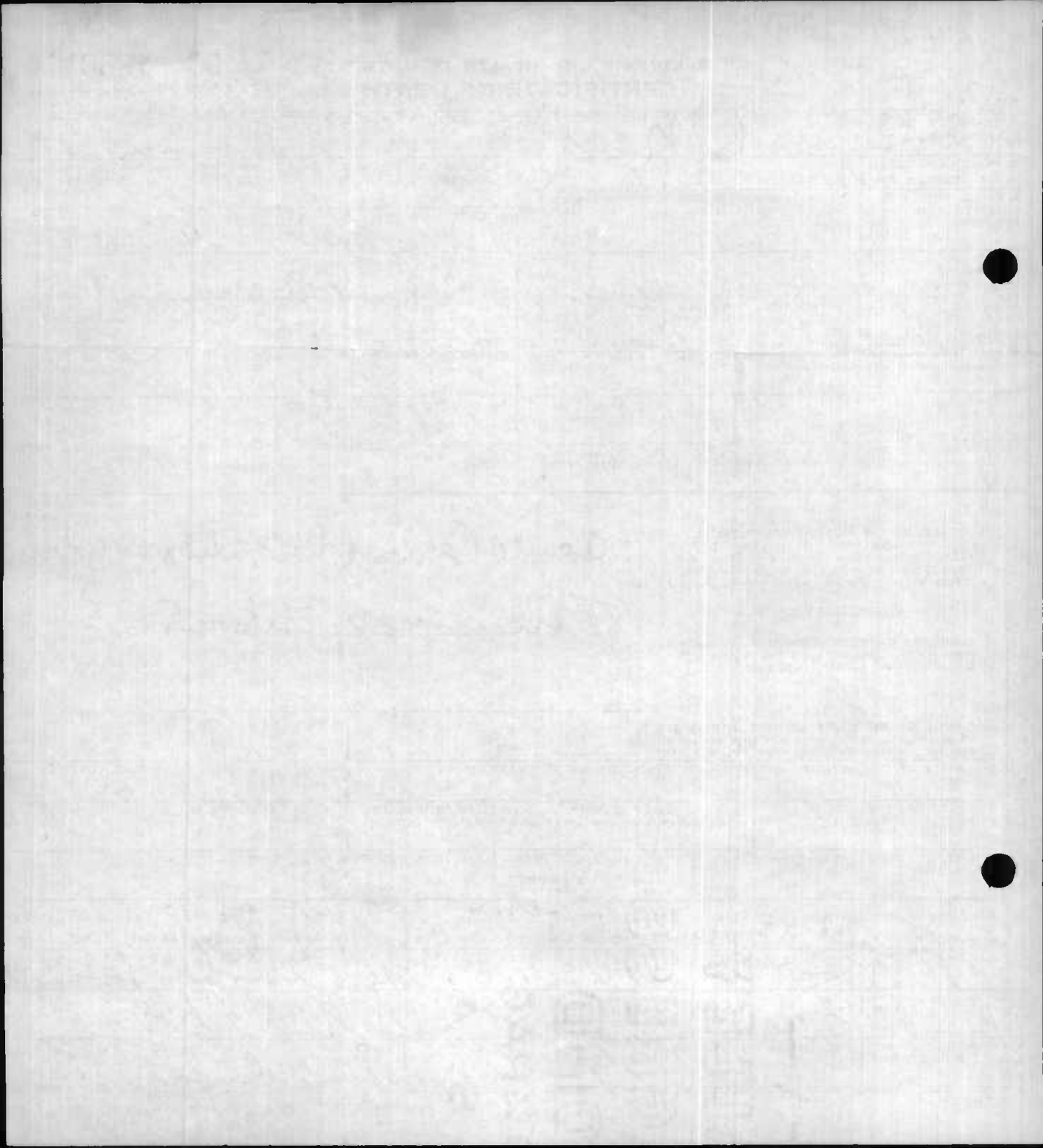
FEB 26 1950

VS 150

MEDICAL CERTIFICATION

FEB 26 1950

VS 150



W-300

50 1661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1661
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John C. White

2. DATE
OF
DEATH

2-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

South Baltimore General Hospital

C. Length of stay in Baltimore

40 Yrs.
Mons.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

DIVORCED

8. DATE OF BIRTH

3/23-1881

9. AGE (In years
last birthday)

68

10 Under 1 Year
Months; Days11 Under 24 Hours
Hours; Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Glass Blower

10B. KIND OF BUSINESS OR
INDUSTRY

Bottles - Glass House

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John C. White

14. MOTHER'S MAIDEN NAME

Hannah Pettit

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

216-07-5301

17. INFORMANT

Walter C. White 2300 E. Lafayette Ave

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Diverticulosis of colon

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/19, 1950, to 2/24, 1950, that I last saw the deceased alive on 2/24, 1950, and that death occurred at 12:55 P.m., from the causes and on the date stated above.

23A. SIGNATURE

David D. Grijan

M. D.

23B. ADDRESS

1213 Light Street

23C. DATE SIGNED

2/24/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Feb-27-1950

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Balto - Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

FEB 26 1950

REGISTRAR'S SIGNATURE

William M. Williams

25. FUNERAL DIRECTOR

Mr. Mrs. John R. Deifel, Son 5311 Edmondson Ave

ADDRESS

VS 150

49625500001663

93D

MEDICAL CERTIFICATION

Inter-urban Mail Service

Postmaster's Office

W. J. Johnson

H-142

50 1662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH53 50 1662
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FANNIE B. HAVELOCK		2. DATE OF DEATH 2-24-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 3501 Traylor Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-19	
D. STREET ADDRESS (If rural, give location) 3501 Traylor Ave		E. LENGTH OF STAY IN BALTIMORE 45 Yrs. Mos. Days	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 2
9. AGE (In years, last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Frank	
14. MOTHER'S MAIDEN NAME Not known		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT Isador Havelock	
18. ADDRESS 3501 Traylor Ave			

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Carcinoma of sigmoid with metastases to liver, lung, + brain****2 yrs**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from **Feb 14, 1950** to **Feb 24, 1950**, that I last saw the deceased alive on **Feb 14, 1950**, and that death occurred at **7 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 26 1950

1950 0001664

46E

MEDICAL CERTIFICATION

Gross

J-120
50 1663Japko
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1663
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Benjamin Japko</i>			2. DATE OF DEATH <i>Feb. 25, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Union Memorial Hosp</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
6. Length of stay in Baltimore Yrs. <i>0</i> Mos. <i>0</i> Days <i>0</i>			D. STREET ADDRESS (If rural, give location) <i>2201 E. Biddle Street</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>?</i>	9. AGE (In years last birthday) <i>60</i>	10. Under 1 Year Months: <i>0</i> Days: <i>0</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Tailor</i>	11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Morris Japko</i>			14. MOTHER'S MAIDEN NAME <i>Rica</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Rose Goldstein</i>		
			ADDRESS <i>3840 Dalfield Ave</i>		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <i>General Peritonitis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>34 hrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <i>Perforated Sigmoid Colon</i>	<i>34 hrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) <i>Carcinoma of Sigmoid</i>	<i>?</i>

19A. DATE OF OPERATION <i>2-24-50</i>	19B. MAJOR FINDINGS OF OPERATION <i>General Peritonitis, Carcinoma of Sigmoid</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2-24-*, 19*50* to *2-25*, 19*50* that I last saw the deceased alive on *2-25*, 19*50*, and that death occurred at *6:55 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Sam E. Gordon M.D.</i>	23B. ADDRESS <i>Union Memorial Hosp</i>	23C. DATE SIGNED <i>2-25-50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2-26-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Hebrew Mt Carmel</i>	24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>William M. Williams</i>	25. FUNERAL DIRECTOR <i>Jack Lewis</i>	ADDRESS <i>2100 Canton Rd</i>

VS 150

36065

1665

46E

200

F-624
50 1664

BALTIMORE CITY HEALTH DEPARTMENT

50 1664

CERTIFICATE OF DEATH 181 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Dominic Fracalossi</u>		2. DATE OF DEATH <u>February 24, 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>6-01</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <u>Baltimore</u>	
D. LENGTH OF STAY IN BALTIMORE <u>23</u>		D. STREET ADDRESS (If rural, give location) <u>23 N. Patomac St.</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>6-4-91</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe mfg.</u>		9. AGE (In years; last birthday) <u>58</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Shoe Co.</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Fracalossi</u>	
14. MOTHER'S MAIDEN NAME <u>Charlotte Bianchi</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>214-01-9104</u>		17. INFORMANT ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Left Psoas Abscess</u>		<u>3 weeks</u>
A. DUE TO		
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Cutaneous Ulcerations</u> <u>Arteriosclerosis following</u> <u>ulcers - 24 months</u> <u>and Total Atherosclerosis</u> <u>Bas Cavum of the</u> <u>Brain</u>		<u>2 months</u> <u>8 years</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>2-22-50</u>	19B. MAJOR FINDINGS OF OPERATION <u>Psoas abscess</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-20, 1950, to 2-24, 1950, that I last saw the deceased alive on 2-24, 1950, and that death occurred at 6:50 P.M., from the causes and on the date stated above.

23A. SIGNATURE <u>John F. Hyman Jr.</u>	23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>	23C. DATE SIGNED <u>2/24/50</u>
--	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>Feb-28, 1950</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>FEB 26 1950</u>	REGISTRAR'S SIGNATURE <u>William</u>	25. FUNERAL DIRECTOR <u>John A. Moran</u>	ADDRESS <u>3000 E. Balt. Rd</u> <u>Balt.-24 Md.</u>

VS 150

4962, 50000 666 52B

DECLARATION OF DEATH

1. Name of deceased		2. Date of death	
3. Place of death		4. Cause of death	
5. Signature of declarant		6. Signature of witness	
7. Signature of physician		8. Signature of coroner	
9. Signature of registrar		10. Signature of clerk	
11. Signature of undertaker		12. Signature of funeral home	
13. Signature of cemetery		14. Signature of church	
15. Signature of other		16. Signature of other	
17. Signature of other		18. Signature of other	
19. Signature of other		20. Signature of other	
21. Signature of other		22. Signature of other	
23. Signature of other		24. Signature of other	
25. Signature of other		26. Signature of other	
27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other	
31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other	
35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other	
39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other	
43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other	
47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other	
51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other	
55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other	
59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other	
63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other	
67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other	
71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other	
75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other	
79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other	
83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other	
87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other	
91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other	
95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other	
99. Signature of other		100. Signature of other	

L-200

50 1665

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1665

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

George J. Louis

2. DATE
OF
DEATH

Feb. 24th. 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

620 St. Dunstons Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

620 St. Dunstons Rd.

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 26th. 1879

9. AGE (In years last birthday)

70

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Police Lieut.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Joseph Louis

14. MOTHER'S MAIDEN NAME

Pauline Schriber

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret E. Louis 620 St. Dunstons Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary artery occlusion.

7 hours.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 23, 1950, to Feb. 24, 1950, that I last saw the deceased alive on Feb. 23, 1950, and that death occurred at 1 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

701 N. Kenwood Ave.

23C. DATE SIGNED

2/24/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2/27/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Baltimore Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

3000 E. Balto. St

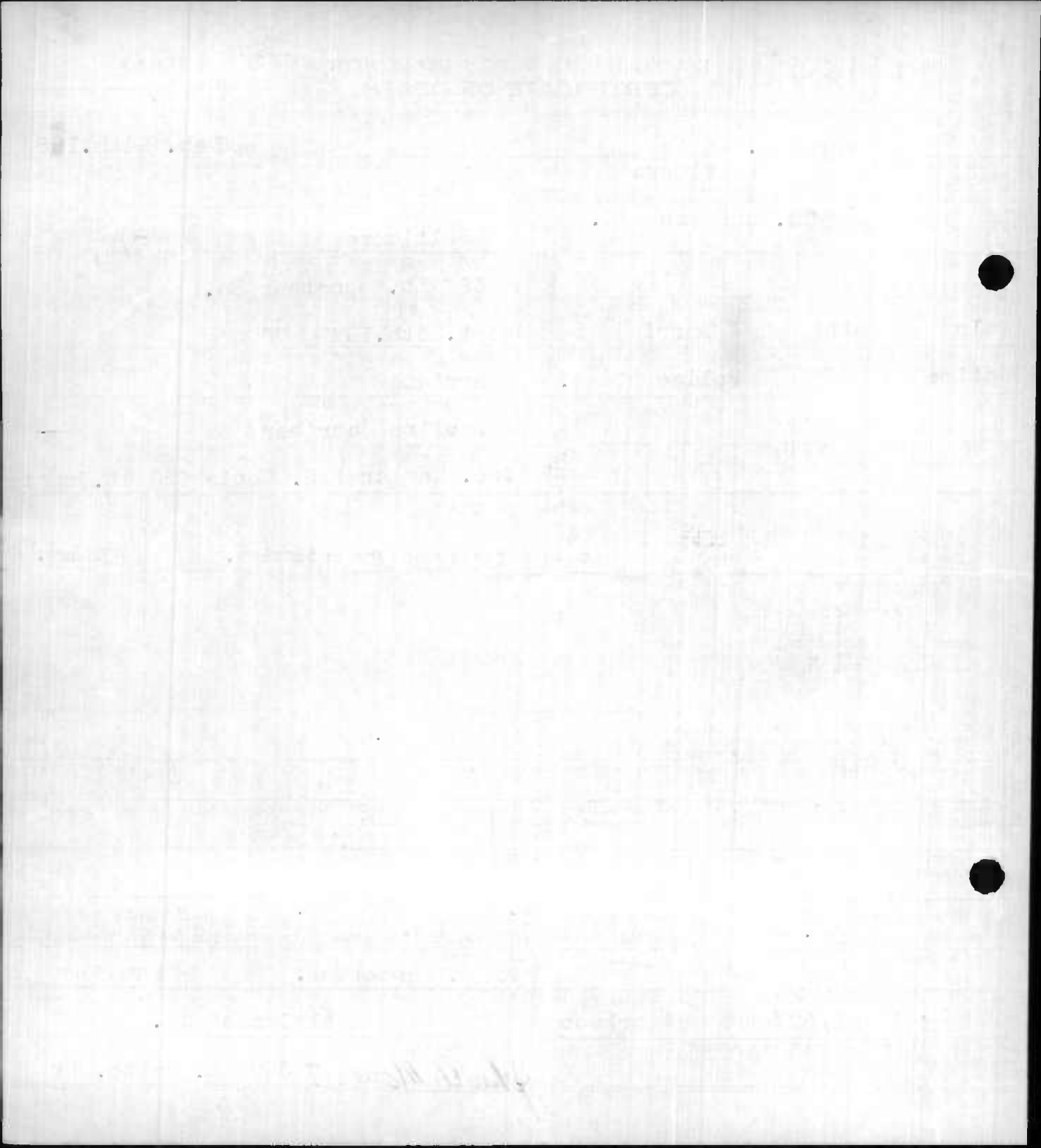
FEB 26 1950

VS 150

604980

94a

MEDICAL CERTIFICATION



5-530

50 1666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

443 50 1666

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edward L. Schmidt

2. DATE
OF
DEATH

Feb. 24th., 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

City

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION 643 Gutman Avenue

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

643 Gutman Avenue

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 15, 1884

9. AGE (In years last birthday)

65

10 Under 1 Year
Months: Days

8

9

11 Under 24 Hours
Hours: Min.

8

9

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Teamster

10B. KIND OF BUSINESS OR INDUSTRY

Paper Company

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Nicholas Schmidt

14. MOTHER'S MAIDEN NAME

Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

None

16. SOCIAL SECURITY NO.

216-07-8920

17. INFORMANT

ADDRESS

Mr. George M. Schmidt-643 Gutman Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Failure of both rt & left ventricles

10 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertensive Disease

3

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 15, 1949, to 24 Feb, 1950, that I last saw the deceased alive on 24 Feb, 1950, and that death occurred at 3:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Samuel Schepers, D.

23B. ADDRESS

714 E. Preston St

23C. DATE SIGNED

25 Feb 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2-27-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county)

Belair Rd. Balto: Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

George J. Ruth, Inc.

25. FUNERAL DIRECTOR

ADDRESS

George J. Ruth, Inc.-1735 Harford Avenue

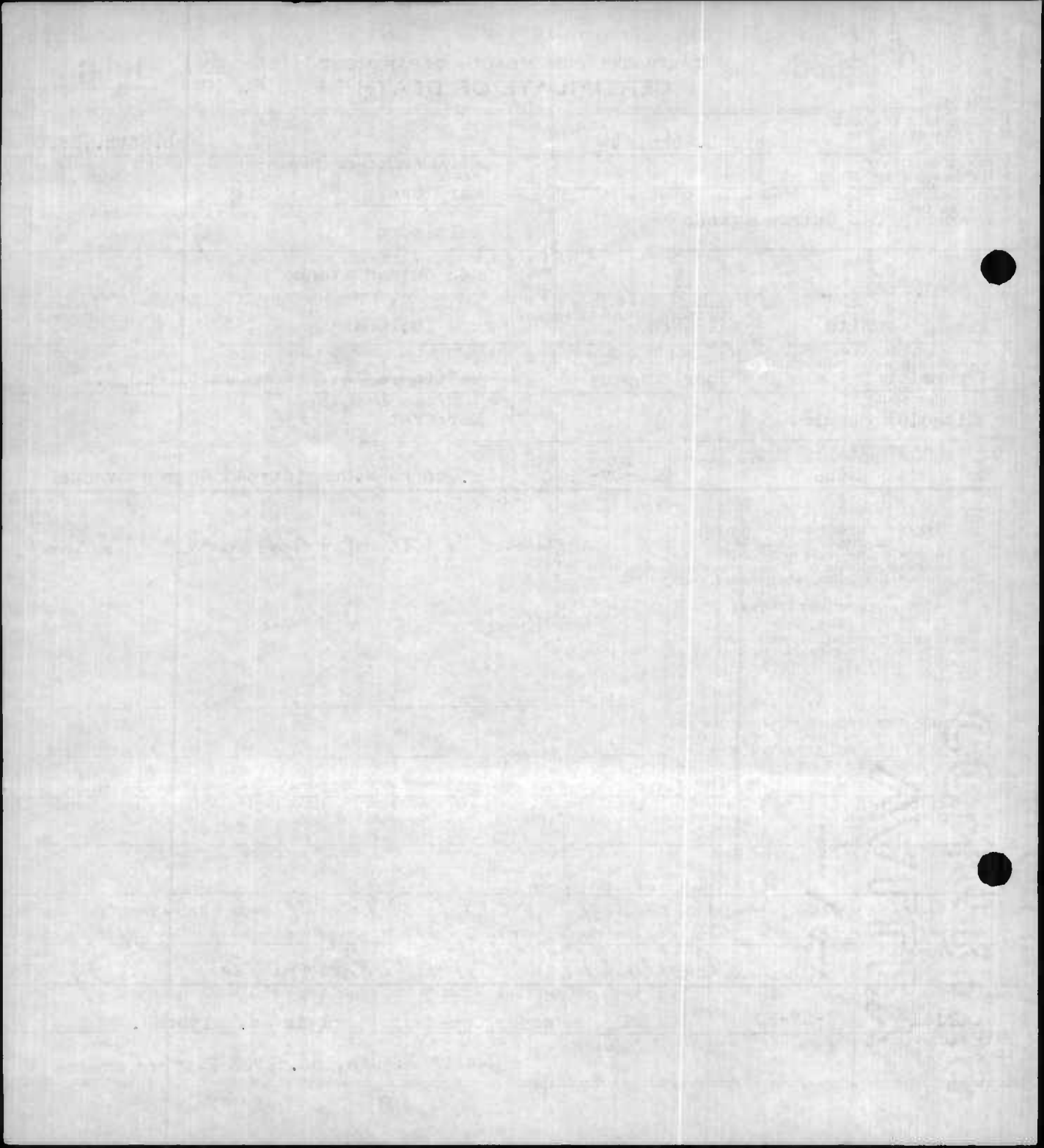
VS 150

91013

000001668

93D

MEDICAL CERTIFICATION



R-260
50 1667BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH43 50 1667
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alice A. Rictor		2. DATE OF DEATH Feb. 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 624 Wildwood Pkwy.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-08	
D. Length of stay in Baltimore 70 Yrs.		E. STREET ADDRESS (If rural, give location) 624 Wildwood P arkwas	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Mch. 24, 1869
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 80
11. BIRTHPLACE (State or foreign country) Howard Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas Blaney		14. MOTHER'S MAIDEN NAME Isabel Weatherstone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary I. Brown 624 Wildwood Pkwy.		ADDRESS	

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardio vascular disease.	INTERVAL BETWEEN ONSET AND DEATH 5 Yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 1	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **June 7:35** 19 **45**, to **Feb. 23,** 19 **50**, that I last saw the deceased alive on **Feb. 23,** 19 **50**, and that death occurred at **7:35** p. m., from the causes and on the date stated above.

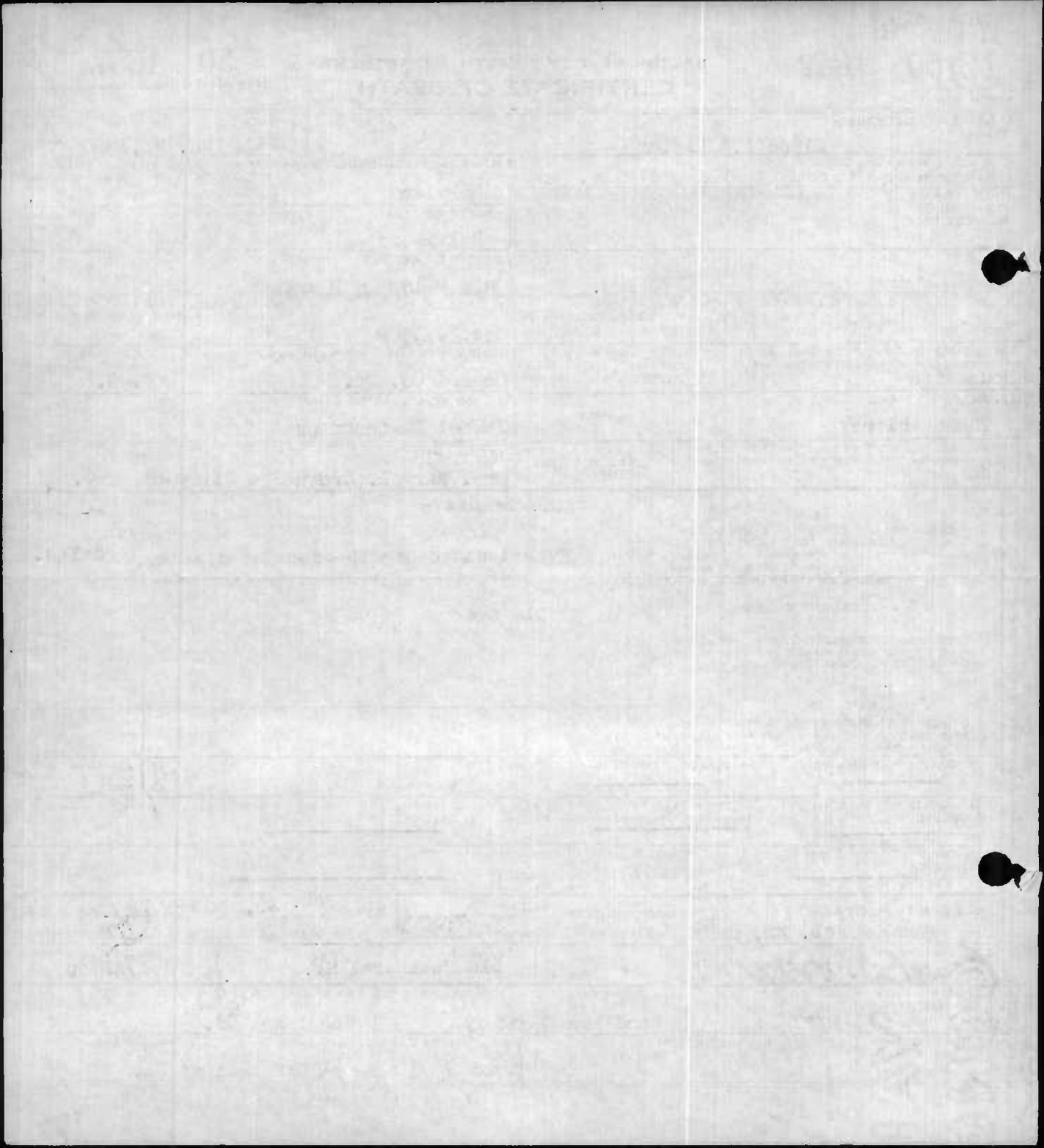
23A. SIGNATURE **Amat S. Morris** M. O. 23B. ADDRESS **516 Cathedral St.** 23C. DATE SIGNED **2/25/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/27/50	24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	24D. LOCATION (City, town, or county) (State) Woodlawn Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Wm. Williams	25. FUNERAL DIRECTOR Geo. L. Bayer Jr.	ADDRESS 1512 Hollins St.

FEB 26 1950
VS 150

1669

937



K-523

Kincaid

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1668

BIRTH NO. 50 1668

1. NAME OF DECEASED
(Type or Print)

Virginia Kincaid

2. DATE
OF
DEATH

Feb 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4 Park Drive

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

12-19-76

9. AGE (In years
last birthday)

73

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ramsey, W. Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Mc Chuston

14. MOTHER'S MAIDEN NAME

Mervina Halstead

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of the thyroid

DUE TO

3 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

2-2-50

19B. MAJOR FINDINGS OF OPERATION

Extension of carcinoma widely into mediastinum

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-23-, 1950 to 2-25-, 1950 that I last saw the deceased alive on 2-25-, 1950, and that death occurred at 3:35 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Dwight C. McKoon

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

2-25-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

2/26/50

24C. NAME OF CEMETERY OR CREMATORY

Highlawn Memorial

24D. LOCATION (City, town, or county)

Oak Hill, W. Va.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William J. Tickner, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tickner & Sons North and Pa. Aves

FEB 28 1950

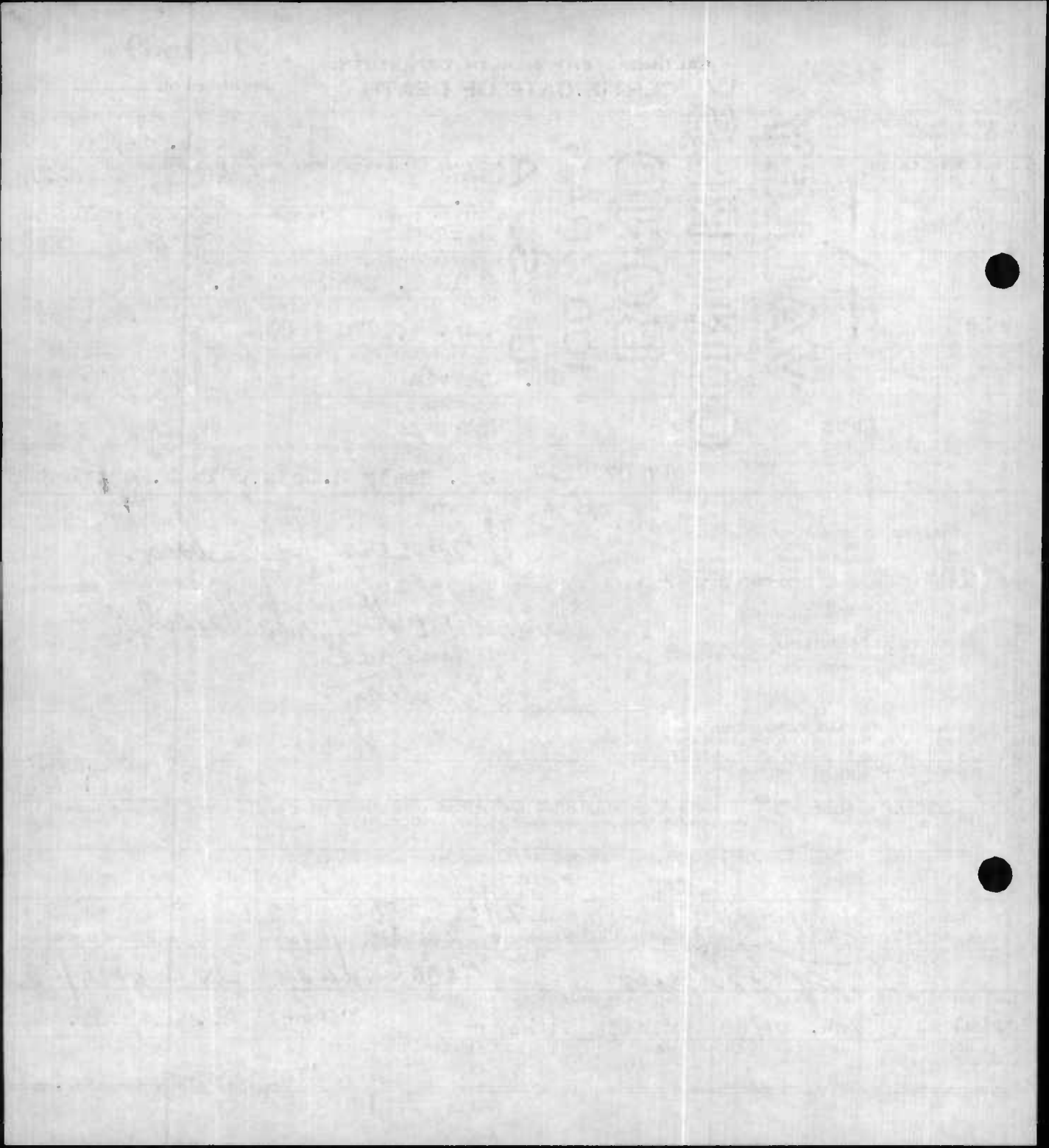
1670 55c

MEDICAL CERTIFICATION

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

X



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Charlotte P. Hill

2. DATE
OF
DEATH

FEB 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

ARDLEIGH NURSING HOME

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE

D. STREET ADDRESS (If rural, give location)
1002 W 38th ST.

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
WIDOW

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOMER

10B. KIND OF BUSINESS OR INDUSTRY
-

13. FATHER'S NAME

TALBOTT LOWE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

JAN 1, 1866

9. AGE (In years last birthday)

84

11 Under 1 Year Months Days 11 Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?
U.S.

14. MOTHER'S MAIDEN NAME

MIRAH J. EBAUGH.

17. INFORMANT

ADDRESS

MRS. GEORGE ROBERT 1002 W 38th ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Arteriosclerosis CVD

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Cardiac Decompensation

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Generalized arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Aug 5, 1947** to **2-27, 1950**, that I last saw the deceased alive on **2-27, 1950**, and that death occurred at **1 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Lawrence J. Schuman

M. D.

3711 Falls Rd

2-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

FEB 27, 1950

GREEN MOUNT

YORK, PA.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

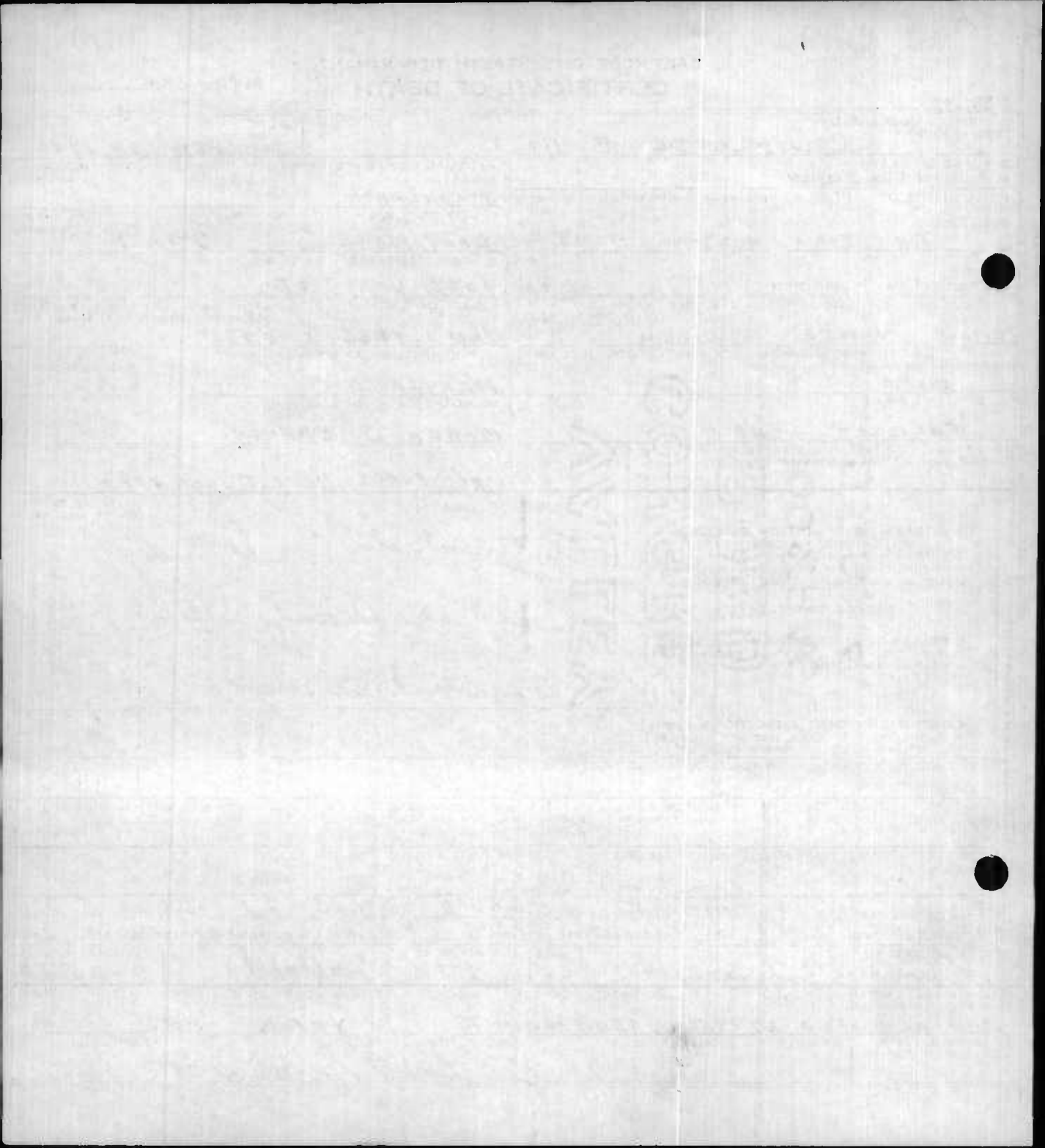
FEB 25 1950

William E. Williams

Trustin E. Donovan 3818 Roland Ave

93D

MEDICAL CERTIFICATION



5250 1671		BALTIMORE CITY HEALTH DEPARTMENT		774 50 1671	
BIRTH NO. 50-04051		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) Baby Girl Emmons		2. DATE OF DEATH 2/26/50			
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Bon Secours Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-02			
Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 2529 W. Fayette ST.			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 2/23/50	9. AGE (In years last birthday)	10. Under 1 Year Months: Days: 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) BALTO MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME PAUL Emmons			
14. MOTHER'S MAIDEN NAME VIOLET Rowzee		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS PAUL EMMONS, 3529 W FAYETTE ST			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PRE-MATURITY DUE TO "RESP. FAILURE"		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) 255. Twin DUE TO					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/23/50, 1950, to 2/26, 1950, that I last saw the deceased alive on 2/25, 1950, and that death occurred at 3:30 a.m., from the causes and on the date stated above.					
23A. SIGNATURE William S. Womack		23B. ADDRESS Bon Secours Hosp		23C. DATE SIGNED 2/26/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 2/27/50		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Bur	
24D. LOCATION (City, town, or county) (State) Woodlawn Ave		25. FUNERAL DIRECTOR ADDRESS Chas P Towell 2427 Edmondson Ave			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE W. S. Womack		159	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1672**

BIRTH NO. **140**

1. NAME OF DECEASED (Type or Print) Rebecca Sehee			2. DATE OF DEATH Feb 22, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 1501 Keweenaw			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-01		
D. STREET ADDRESS (If rural, give location) 1501 Keweenaw			E. LENGTH OF STAY IN BALTIMORE 25 years		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 4, 1875	9. AGE (in years, last birthday) 75	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hampton Va		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Seldor			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Henry Sehee 1501 Keweenaw		

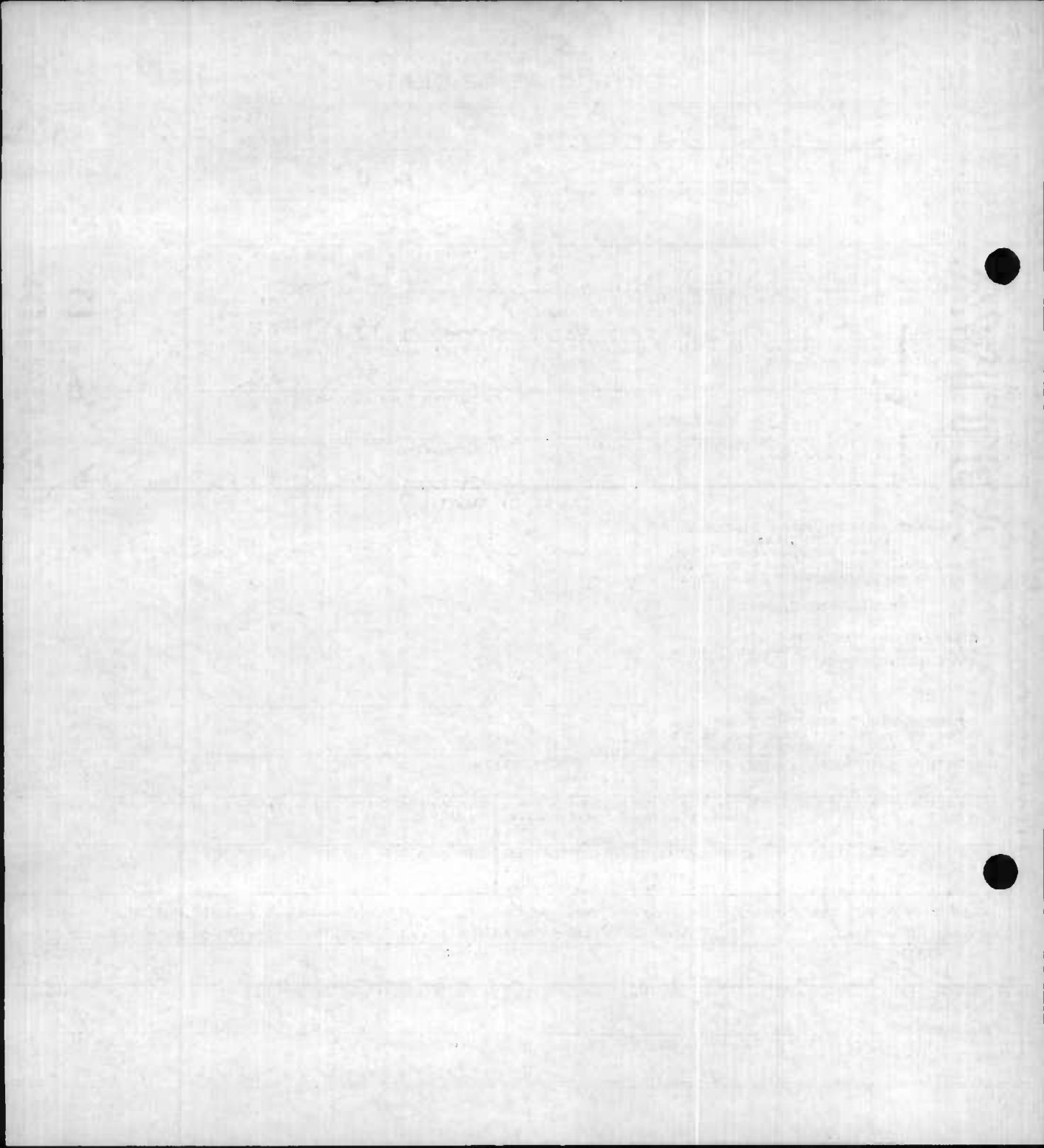
<p>18. I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p align="center">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) Coronary Vascular Disease</p> <p align="center">DUE TO</p> <p>(B)</p> <p align="center">DUE TO</p> <p>(C)</p> <p align="right">INTERVAL BETWEEN ONSET AND DEATH 2 years</p>
---	---

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb 7, 1950** to **Feb 22, 1950**, that I last saw the deceased alive on **Feb 22, 1950** and that death occurred at **4:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE William H. Werts	23B. ADDRESS 5153 Keweenaw	23C. DATE SIGNED 2/26/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/26/50	24C. NAME OF CEMETERY OR CREMATORY Arbutus
24D. LOCATION (City, town, or county) (State) Baltimore Md		25. FUNERAL DIRECTOR Geo. E. Nelson
26. RECEIVED BY LOCAL REGISTRAR FEB 27 1950		27. REGISTRAR'S SIGNATURE William H. Werts

001674 937



536
50 1673

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

493 50 1673
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Annie Henderson

2. DATE
OF
DEATH

2-23-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

Maryland

b. FULL NAME OF
HOSPITAL OR
INSTITUTION

3328 Fairfield Road.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

a. STATE

b. COUNTY

Maryland

c. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore - 25

d. STREET ADDRESS (If rural, give location)

3328 Fairfield Road.

5. SEX

FEMALE

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 3, 1878 78

9. AGE (In years
last birthday)

11 Under 1 Year
Months: Days Hours: Min.

11 5 - -

10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Henderson, N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Not Known.

14. MOTHER'S MAIDEN NAME

Boley Evans.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

son.

ADDRESS

Honnie Henderson 3328 Fairfield Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Pneumonia

DUE TO

5 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Senility

DUE TO

(C)

Dehydration

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21d. TIME (Month) (Day) (Year) (Hour)
INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 2-17, 1950, to 2-23, 1950, that I last saw the
deceased alive on 2-22, 1950, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE

Jerry L. Luck

M.D.

23b. ADDRESS

427 Swale Ave

23c. DATE SIGNED

2-23-50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

Burial

2-27-50

24c. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cemetery

24d. LOCATION (City, town, or county)

Balti.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

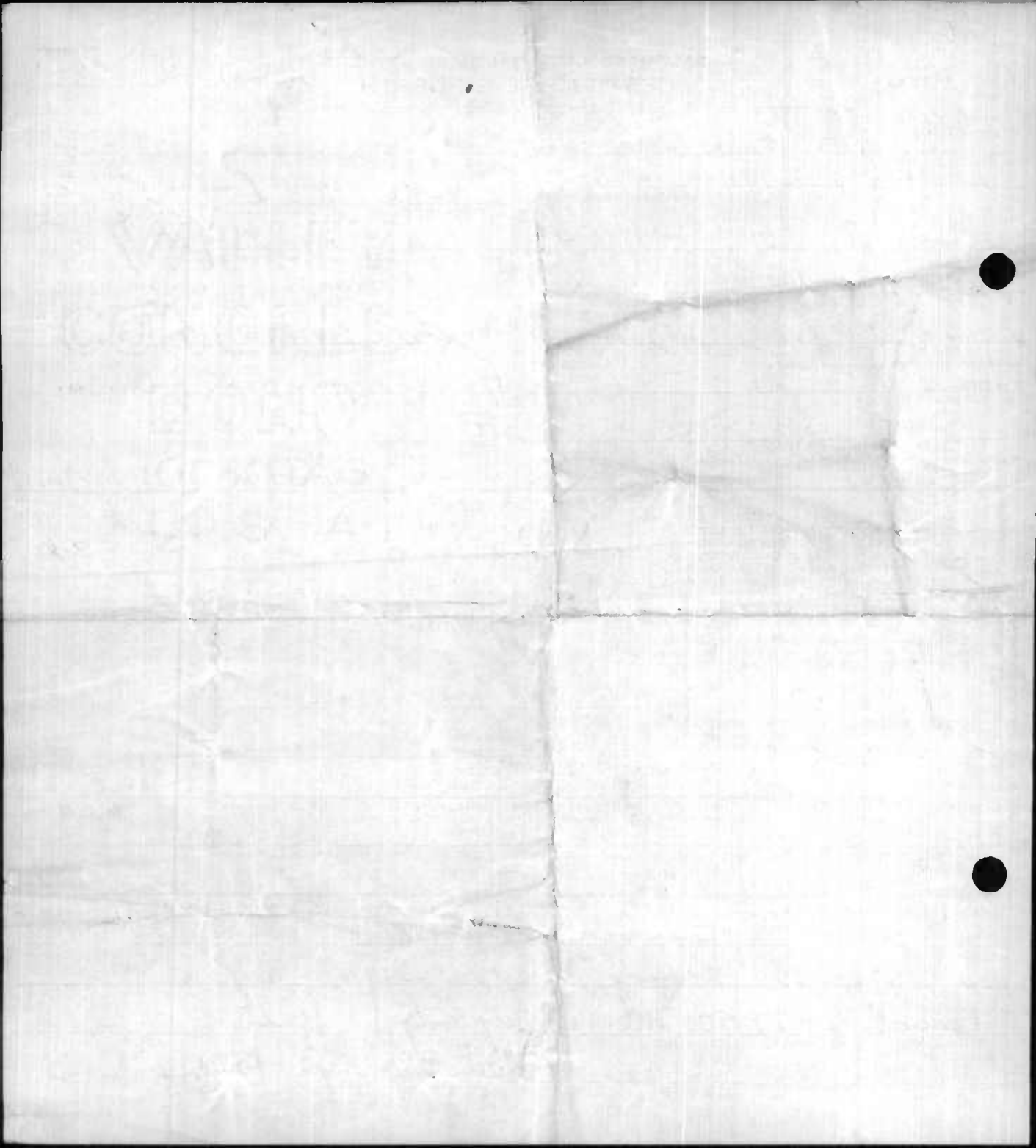
REGISTRAR'S SIGNATURE

FEB 27 1950

25. FUNERAL DIRECTOR

ADDRESS

Walter B. Spriggs 139 W. Hamburg St.



620

1674-135865

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1674

Registered No.

BIRTH NO. 50-02669

1. NAME OF DECEASED
(Type or Print) Deborah Ann Harris2. DATE
OF DEATH 2-21-503. PLACE OF DEATH:
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTYB. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital
4940 Eastern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 26-06

Length of stay in Baltimore Life

Yrs.
Mos.
DaysD. STREET ADDRESS (If rural, give location)
5700 Swallow Lane -245. SEX
Female6. COLOR OR RACE
Negro7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single8. DATE OF BIRTH
Feb. 9, 19509. AGE (In years last birthday) 12
11 Under 1 Year Months Days
11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Harris

14. MOTHER'S MAIDEN NAME
Ida Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
B. C. H. Records, 4940 Eastern Ave.

18. 756.2

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Septicemia Obstructive jaundice

(over)

DUE TO

ANTECEDENT CAUSES

(B)

Hypoplasia of hepatic duct

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Prematurity.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-17, 1950 to Feb. 21, 1950 that I last saw the deceased alive on Feb. 21, 1950 and that death occurred at 1.45 PM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED
Feb. 23, 195024A. BURIAL, CREMATION, REMOVAL (Specify)
Cremated

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

VS 150

159

See Document File 50-1674
Amendment Authority
3/5/1951 ES

000 18-135921
00 1675

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

761.0 50 1675
Registered No.

BIRTH NO. 50-03476

1. NAME OF DECEASED (Type or Print) Scott, Baby Girl-Helen			2. DATE OF DEATH 2-19-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-01		
Length of stay in Baltimore Life Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 26 S. Spring Street.		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH February 19, 1950		9. AGE (In years last birthday) 28 If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Vernon Scott			14. MOTHER'S MAIDEN NAME Helen Makell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS 4940 Records*Balto. City Hospitals Eastern Ave.		

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Anoxia**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **cyclopropane anesthetic**

DUE TO

(C)

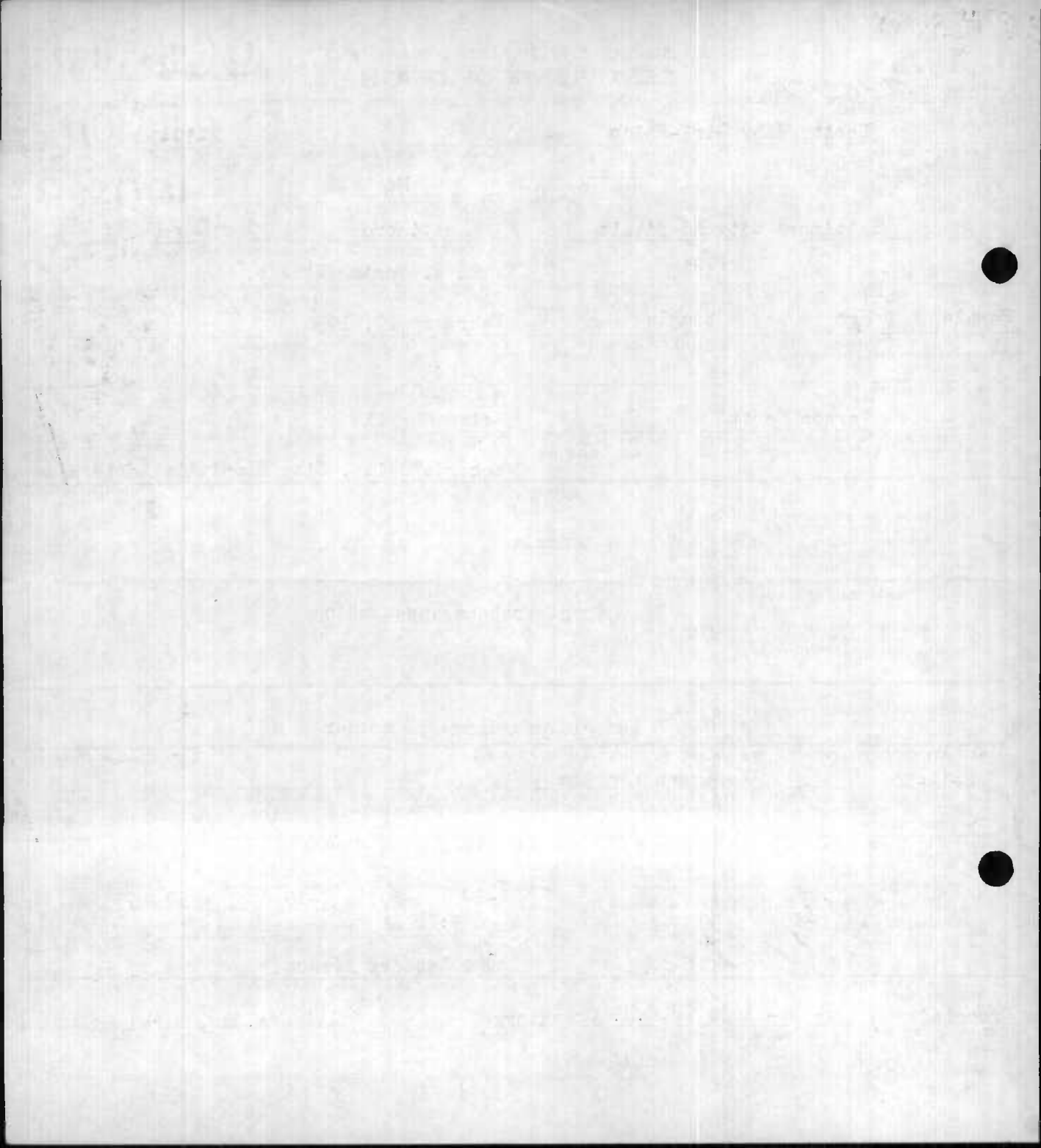
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Toxemia pregnancy in mother

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION 2-19-50		19B. MAJOR FINDINGS OF OPERATION Cesarean section		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-19, 1950 to 2-19, 1950 , that I last saw the deceased alive on 2-19, 1950 and that death occurred at 9:00 A. , from the causes and on the date stated above.					
23A. SIGNATURE <i>J.S. Rogers</i>		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 2-21-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated		24B. DATE 2-21-1950		24C. NAME OF CEMETERY OR CREMATORY B.C.H. Crematory	
DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950		REGISTRAR'S SIGNATURE <i>Smith for Williams, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS Baltimore, 24, Maryland	



430

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1676
Registered No.

BIRTH NO. 50-03131

1. NAME OF DECEASED (Type or Print) Infant Howlett		2. DATE OF DEATH Feb. 14, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Maryland General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-07	
C. Length of stay in Baltimore 1 Day Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 318 W. Lorraine Ave.	
5. SEX Fe	6. COLOR OR RACE Whi.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH 2/14/50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years; last birthday) — Under 1 Year Months: Days Hours: Min. — — — 40	
10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wilbur Martin Howlett	
14. MOTHER'S MAIDEN NAME Teresa Cecelia Arduin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. No		17. INFORMANT Mother ADDRESS 318 W. Lorraine	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)		40 min.
(A) Non-Viable Premature (24 weeks) DUE TO		
(B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 9:05 AM 2/14, 1950 , to 9:45 PM 2/14, 1950 , that I last saw the deceased alive on 2/14, 1950 , and that death occurred at 9:45 AM , from the causes and on the date stated above.				
23A. SIGNATURE Walter C. Friday	23B. ADDRESS Md. Gen. Hosp.	23C. DATE SIGNED 2/15/50		
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24B. DATE 2-16-50	24C. NAME OF CEMETERY OR CREMATORY Maryland General Hosp.	24D. LOCATION (City, town, or county) (State) Baltimore 1, Md.	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE Walter C. Friday	25. FUNERAL DIRECTOR		ADDRESS

FEB 27 1950

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

January 1, 1912

TO THE HONORABLE SENATE

AND THE HONORABLE HOUSE OF REPRESENTATIVES

OF THE UNITED STATES OF AMERICA

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

ON DECEMBER 19, 1911

AND BY THE HOUSE OF REPRESENTATIVES

ON DECEMBER 15, 1911

RELATIVE TO THE

PROPOSED AMENDMENT TO THE

CONSTITUTION OF THE UNITED STATES

PROVIDING FOR THE

REVISION OF THE

CONSTITUTION OF THE UNITED STATES

BY THE PEOPLE OF THE UNITED STATES

IN THE YEAR 1912

AND FOR THE

REVISION OF THE

CONSTITUTION OF THE UNITED STATES

BY THE PEOPLE OF THE UNITED STATES

IN THE YEAR 1912

AND FOR THE

REVISION OF THE

CONSTITUTION OF THE UNITED STATES

BY THE PEOPLE OF THE UNITED STATES

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BY THE PEOPLE OF THE UNITED STATES

IN THE YEAR 1912

AND FOR THE

REVISION OF THE

CONSTITUTION OF THE UNITED STATES

BY THE PEOPLE OF THE UNITED STATES

IN THE YEAR 1912

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Czernikowski Or Joseph Zernikowski

2. DATE

OF DEATH 2-11-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

MD.

5. FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street address or location)
Baltimore City Hospitals
4940 Eastern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

? No Home B.C.H.

6. Length of stay in Baltimore

?

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

?

9. AGE (In years,
last birthday)

70 ?

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic Heart Disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Thrombosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 9-16-, 1935, to 2-11-, 1950 that I last saw the
deceased alive on 2-11-1950, and that death occurred at 6.50 AM, from the causes and on the date stated above.

23A. SIGNATURE

P. B. C. C.

M. D.

23B. ADDRESS

B.C.H. 4940 Eastern Ave.

23C. DATE SIGNED

2-17-1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL FEB 20 1950

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

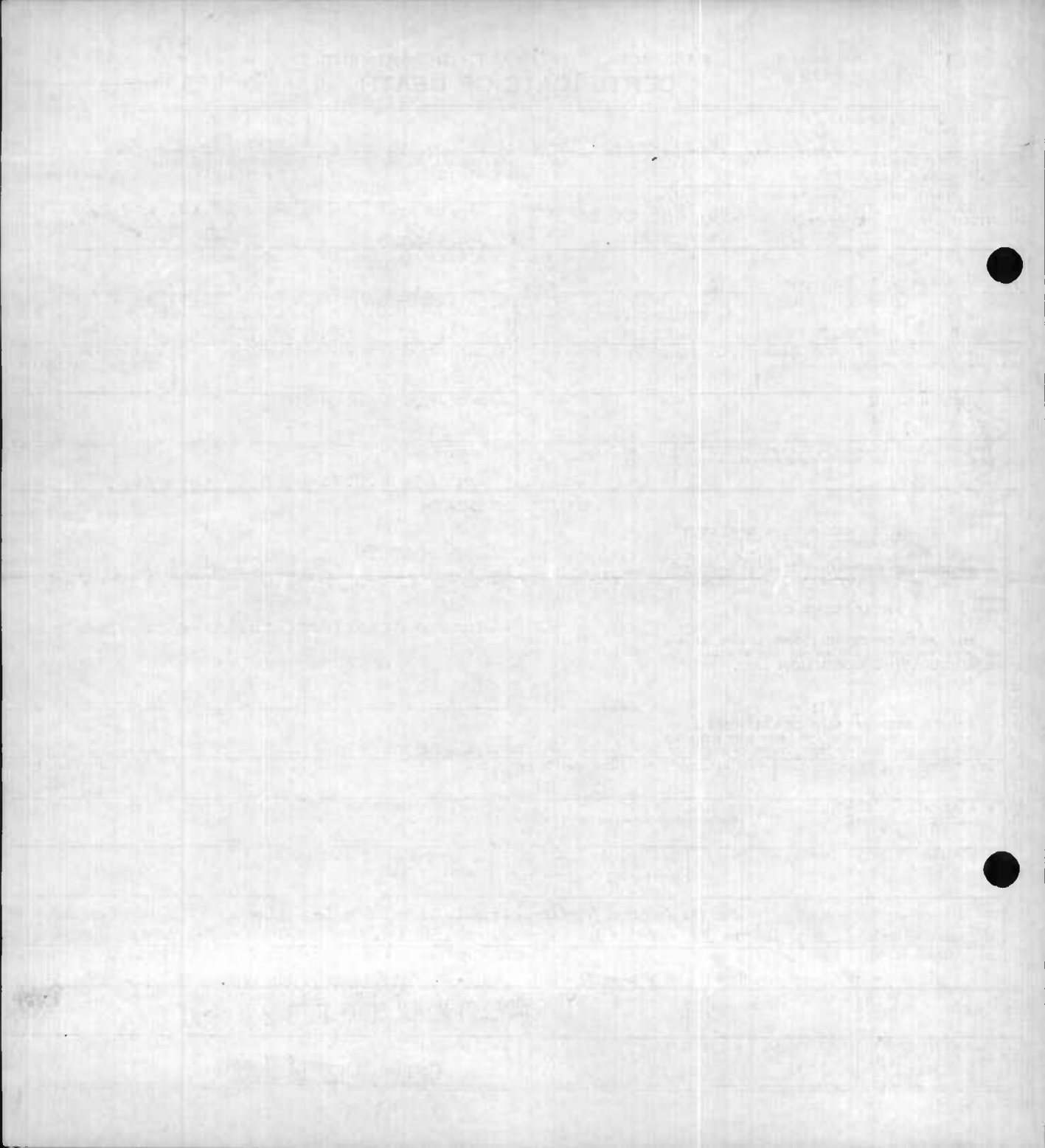
ADDRESS

Commissioner of Health

VS 150

FEB 27 1950

167.933-937



000107

50 1678

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH94 50 1678
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Henrietta S. Bowie

2. DATE
OF
DEATH

2-8-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE MD. B. COUNTY before admission)B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION Baltimore City HospitalsC. CITY OR TOWN (If outside corporate limits, write RURAL and give
Baltimore township)

31 4940 Eastern Ave.

D. STREET ADDRESS (If rural, give location)

740 Ryan ST.

Length of stay in Baltimore ?

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 3-1848 ?

9. AGE (In years
last birthday)

101 ?

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John A. Bowie

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18. CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Senility

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT NOT WHILE
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 1-21-1944 to 2-8-1950, that I last saw the
deceased alive on 2-8-1950, and that death occurred at 100 AM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

B.C.H. 4940 Eastern Ave.

2-15-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. DECEASED'S SIGNATURE

ADDRESS

FEB 27 1950

Huntington Williams

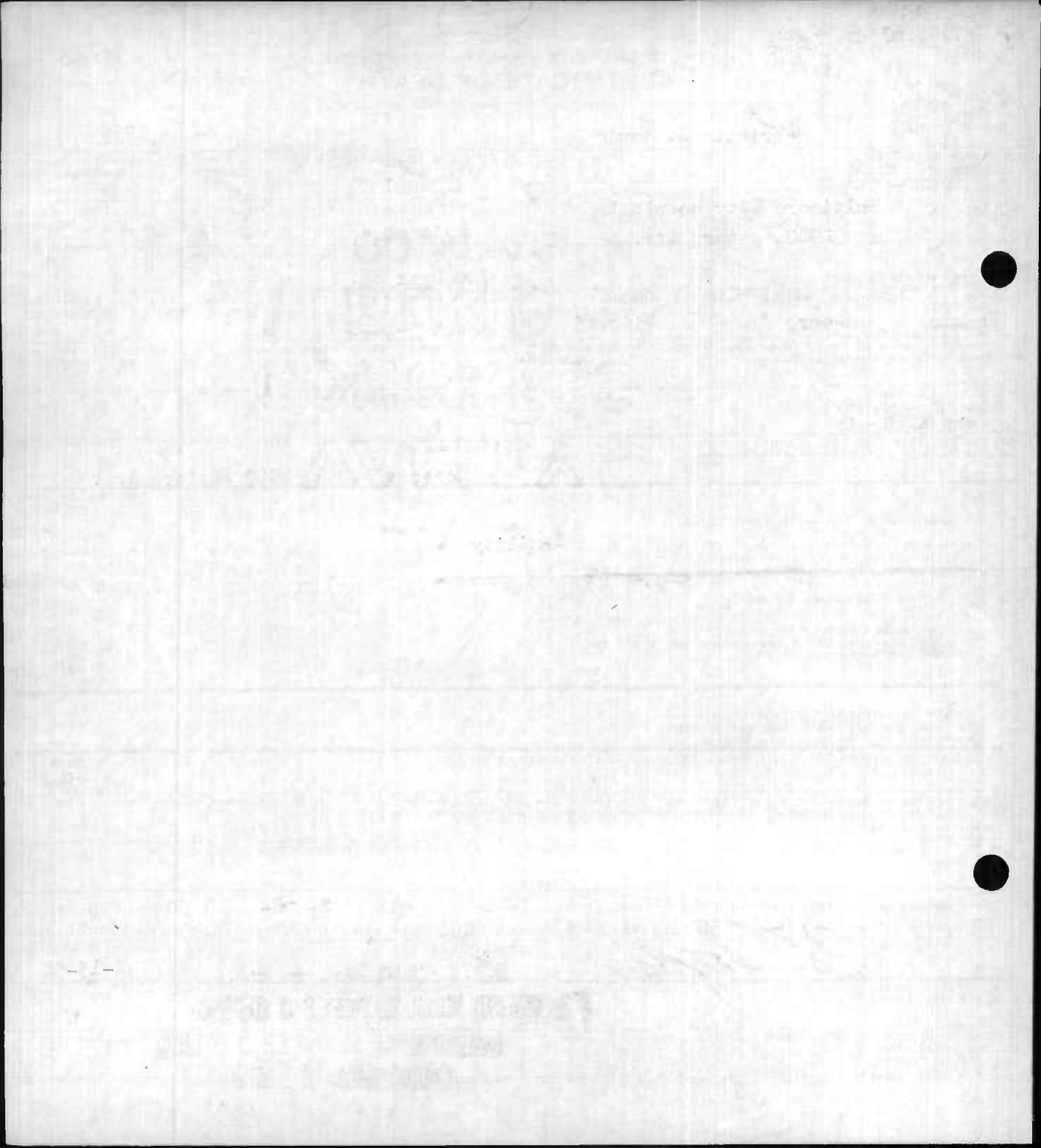
UNIVERSITY MEDICAL SCHOOL FEB 20 1950

Commissioner of Health

VS 150

162 B

MEDICAL CERTIFICATION



200

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1679

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CARRIE FLORENCE BYUS

2. DATE
OF
DEATH

February 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 3402 Walbrook Ave

B. FULL NAME OF
HOSPITAL OR
INSTITUTION4. USUAL RESIDENCE (Where deceased lived, if institution: residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 29, 1869

9. AGE (In years
last birthday)

80

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Retired.

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles W. Banaker

14. MOTHER'S MAIDEN NAME

Johanna Ewell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Audrey Green 3402 Walbrook Ave

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerotic Heart Disease

10 yrs

(C)

Senility

10 yrs

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1931 to Feb 26, 1950, that I last saw the
deceased alive on Feb 20, 1950, and that death occurred at 2:40 A.M., from the causes and on the date stated above.

23A. SIGNATURE

A.S. Chalfant

M. D.

23B. ADDRESS

6210 York Road

23C. DATE SIGNED

Feb 26, 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Feb 28, 50

24C. NAME OF CEMETERY OR CREMATORY

Mt Olivet

24D. LOCATION (City, town, or county)

Balto

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

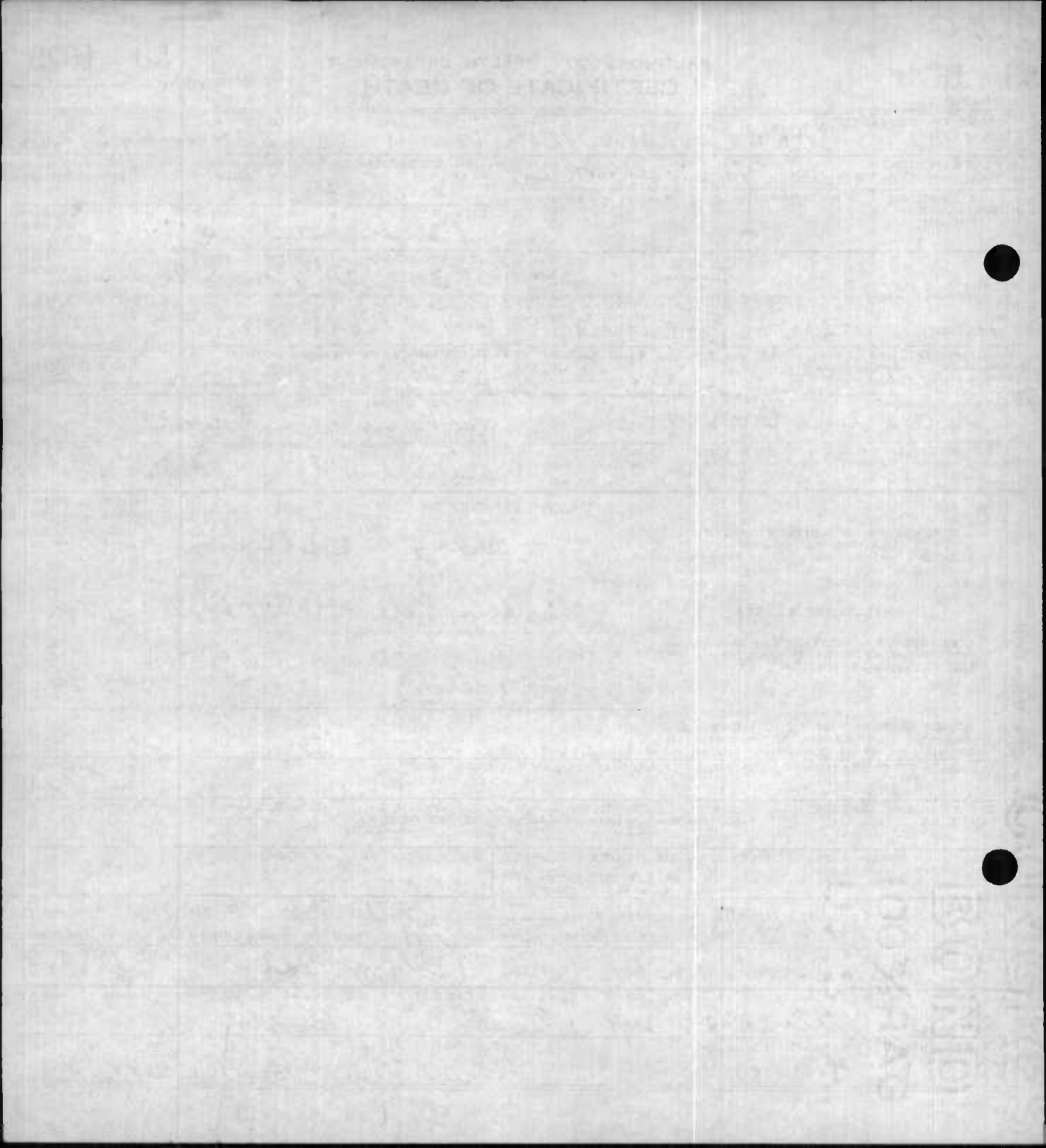
REGISTRAR'S SIGNATURE

William H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2008 Calver



CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Moses

Pearson

2. DATE
OF
DEATH

Feb. 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

518 Hubbard Alley

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

B. DATE OF BIRTH

N

9. AGE (In years
last birthday)

65?

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

U

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

N

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

K

14. MOTHER'S MAIDEN NAME

W

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

N

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) arteriosclerotic Cardiovascular
Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Bronchial Asthma

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., In or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....

23C. DATE SIGNED
Feb. 17, 1950

M.D.

MEDICAL INVESTIGATOR.....

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL FEB 23 1950

Commissioner of Health

RECORDS OF THE
COMMISSIONERS OF DEATH

1900

1900

1900



520 50 1681

CERTIFICATE CORRECTED

3-22-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 1681

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

(ORLANDO) --- RIVELLO) MARION E. THOMAS

2. DATE
OF
DEATH

January 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland- Penna.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Philadelphia

D. STREET ADDRESS (If rural, give location)

22-E. Camden Street (Lighthouse Hotel)

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

N

8. DATE OF BIRTH

U

9. AGE (In years last birthday)

35

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

N

11. BIRTHPLACE (State or foreign country)

Washington, DC

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Lee Thomas

14. MOTHER'S MAIDEN NAME

Emilie F. Ebberts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Leo S. Case

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Alcoholism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

G. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Jan. 26, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

3-23-50

24C. NAME OF CEMETERY OR CREMATORY

UNIVERSITY MEDICAL CENTER FEB 23 1950

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William H. Williams, Jr.

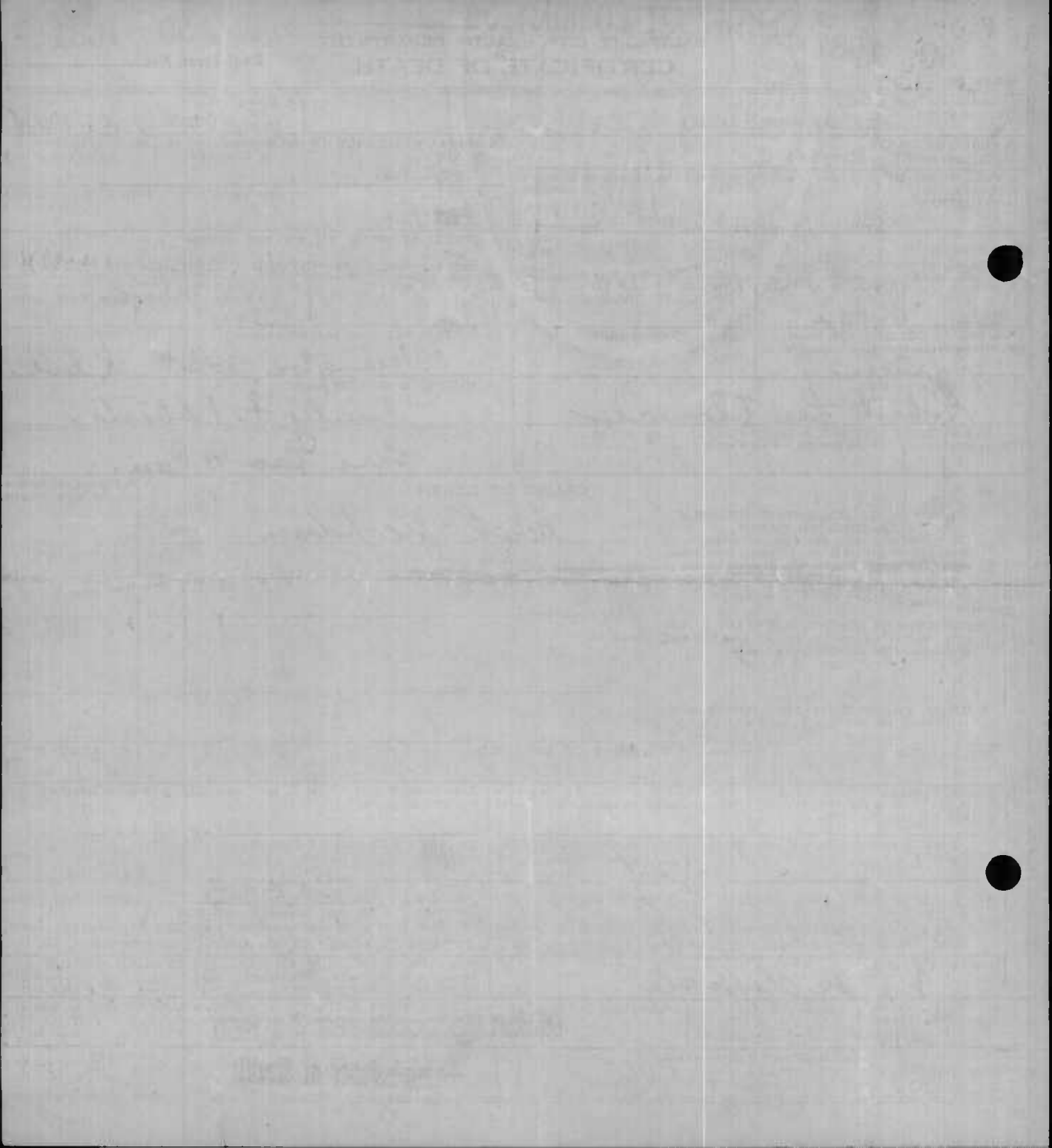
25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

Rockville, Md.

MEDICAL CERTIFICATION



652
50 1682

50 1682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 49°

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Willie Armstead</i>			2. DATE OF DEATH <i>2/24/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Ind.</i> B. COUNTY <i>City</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>937-Park Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 11-02</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>937-Park Ave.</i>		
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Oct. 7 1880</i>		9. AGE (In years last birthday) <i>69</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>	
13. FATHER'S NAME <i>unknown</i>			14. MOTHER'S MAIDEN NAME <i>Mary Francis</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>John W. Armstead</i>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>Ischemic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Feb. 19</i> , 19 <i>50</i> , to <i>Feb 24</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>Feb 24</i> , 19 <i>50</i> , and that death occurred at <i>11:00</i> a. m., from the causes and on the date stated above.					
23A. SIGNATURE <i>W. Johnson</i>		23B. ADDRESS <i>1100 N. Calver</i>		23C. DATE SIGNED <i>Feb 28 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/28</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mount Calvary</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. LOCATION (City, town, or county) <i>Baltimore</i>		24F. LOCATION (City, town, or county) <i>Baltimore</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 27 1950</i>		REGISTRAR'S SIGNATURE <i>William Williams</i>		25. FUNERAL DIRECTOR <i>W. Halstead</i>	
				ADDRESS <i>918 - Alameda Hill Ave.</i>	

MEDICAL CERTIFICATION

FEB 27 1950

1 5 0 0 0 0

108

VALLEY
CONGRESS

100 X 100

100 X 100

100 X 100

350

50 1683

Lod E.M.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH443 50 1683
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Delia Isabel Loden

2. DATE
OF
DEATH

2-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Hospital for Women of Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

28-04

Length of stay in Baltimore

80

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

4600 Manordene Road

5. SEX

7

6. COLOR OR RACE

N

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

10-7-69

9. AGE (In years
last birthday)

80

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

US

13. FATHER'S NAME

Joseph Stivers

14. MOTHER'S MAIDEN NAME

Mary Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Paul Ritter - 4600 Manordene Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

48 hr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular Disease

DUE TO

?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Pneumonia, atypical

4 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 23, 1950, to Feb. 25, 1950, that I last saw the
deceased alive on Feb. 25, 1950, and that death occurred at 11:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John R. Smith, Jr.

M. D. Hosp. for Women of Md. Balto. Md.

2/26/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/1/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral C em.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

FEB 27 1950

REGISTRAR'S SIGNATURE

William J. Williams

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER & SONS

Balto., Md.

STATE OF TEXAS
COUNTY OF _____

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

Notary Public in and for the State of Texas

My commission expires the _____ day of _____, 19____.

Witness my hand and seal of office at _____, Texas, this _____ day of _____, 19____.

625

50 1684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 1684

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)Carson John
Carson, John A.2. DATE
OF
DEATH

2/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

N.Y.

Long Island

5. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hospital

C. CITY OR TOWN

Huntington

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Bay Ave.

Length of stay in Baltimore

1 Days

5. SEX

M

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Feb. 17, 1890

9. AGE (In years
last birthday)

60

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

auto dealer

10B. KIND OF BUSINESS OR
INDUSTRY

Automobile

11. BIRTHPLACE (State or foreign country)

New York State

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John Carson

14. MOTHER'S MAIDEN NAME

Eliz. Welch

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Agnes E. Carson.

ADDRESS

Huntington, N.Y.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

aspiration of vomitus = asphyxia

few minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

cerebral hemorrhage, massive, left

15 3/4 hrs

(C)

Hypertensive CVD

years.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from 2/25, 1950, to 2/26, 1950 that I last saw the deceased alive on 2/26, 1950, and that death occurred at 1:05 P.m., from the causes and on the date stated above.

23A. SIGNATURE

J. R. Hankins

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

2/26/50

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

24B. DATE

2/27/50

24C. NAME OF CEMETERY OR CREMATORY

Huntington, N.Y.

24D. LOCATION (City, town, or county)

Huntington, N.Y.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tickner & Sons North and Pa. Aves

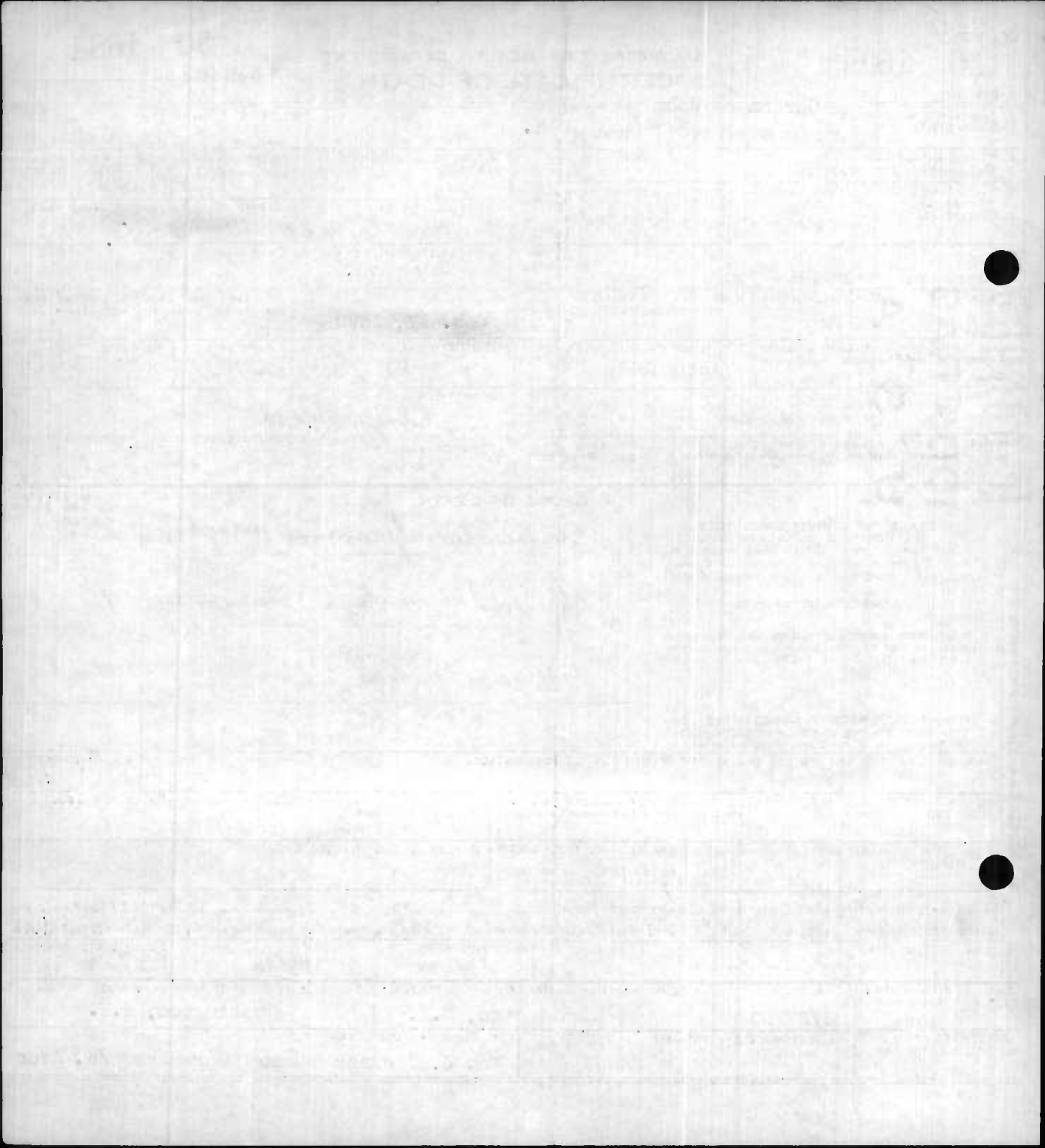
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937

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

50 1685

BIRTH NO. 1685

1. NAME OF DECEASED (Type or Print) <i>Margaret C. Sweeney</i>			2. DATE OF DEATH <i>2-24-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1315 Hillman St.</i>			C. CITY OR TOWN (If outside corporate limits write full name, and give township) <i>Balto - Md. 9-09</i>		
C. Length of stay in Baltimore <i>70</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>1315 Hillman Street</i>		
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>9-8-59</i>		9. AGE (In years last birthday) <i>90</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Boston Mass.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>James Hughes</i>			14. MOTHER'S MAIDEN NAME <i>Mary Ellen ?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT ADDRESS <i>Anna Bernota - 1315 Hillman St.</i>		

CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.	(A) <i>Uremia</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>?</i> <i>?</i>
	(B) <i>Cordis - Vascular - Renal Disease</i> DUE TO	
	(C) <i>arteriosclerosis</i>	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Sept. 1947* to *24 Feb, 1950*, that I last saw the deceased alive on *23 Feb, 1950* and that death occurred at *9:30 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE *Samuel Silerfeld* M. D. 23B. ADDRESS *714 E. Preston St* 23C. DATE SIGNED *25 Feb. 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2-28-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore - Md</i>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>William Williams</i>	25. FUNERAL DIRECTOR <i>Silerfeld & Silerfeld</i>	ADDRESS <i>403 S. Wolfe Street</i>

FEB 27 1950

131a

MEDICAL CERTIFICATION

Dr. Liles, J.H. - 7148: Photo Hunt - Sa. 5756

9-10 - a.m. - 6-8 - P.M.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1686
Registered No.

BIRTH NO. 49-22716

1. NAME OF DECEASED (Type or Print) JOHN C. MCCOY		2. DATE OF DEATH February 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) South Baltimore General Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 701 S. Sharp Street		5. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
6. SEX Male	7. COLOR OR RACE Colored	8. DATE OF BIRTH 10/17/49	9. AGE (In years last birthday) 4 Months 7 Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Baltimore	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James McCoy		14. MOTHER'S MAIDEN NAME Sarah Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sarah McCoy-701 S. Sharp Street		ADDRESS	

18. 053.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Septicemia, organism unidentified (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Dr. J. Mc Clafferty M.D. 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ 23C. DATE SIGNED **2-24-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **2/27/50** 24C. NAME OF CEMETERY OR CREMATORY **Mt Calvary** 24D. LOCATION (City, town, or county) (State) **A.A.Co., Md.**

DATE RECEIVED BY LOCAL REGISTRAR **February 27, 1950** REGISTRAR'S SIGNATURE Montgomery 25. FUNERAL DIRECTOR **I.L. Brown** ADDRESS **108 W - Montgomery**

VS 151- 24a

DEPARTMENT OF HEALTH
OFFICE OF THE DEATH

16020

5-100
50 1687
BIRTH NO. 49-2/681

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1687

1. NAME OF DECEASED (Type or Print) MELVIN (CHERRY) DOBY		2. DATE OF DEATH February 21, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-02	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 115 S. Lloyd Street	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 10-5-49
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME ?		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
	(A) Lobar pneumonia, left lower lobe DUE TO		
	(B) DUE TO		
(C) Chronic excema of buttocks			

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE R. S. Fisher		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Feb. 22, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950		REGISTRAR'S SIGNATURE L. Williams, Jr.		25. FUNERAL DIRECTOR Commissioner of Health	

DECLARATION OF DEED

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N-614
50 1688BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1688
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hunter Norfleet		2. DATE OF DEATH Feb. 9, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Mercy Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Room #3 New Fountain Hotel	
6. Length of stay in Baltimore Yrs. Mos. Days		O. STREET ADDRESS (If rural, give location) 122 E. Pratt St. 4-01	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U	8. DATE OF BIRTH U
9. AGE (In years, last birthday) 42		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		11. BIRTHPLACE (State or foreign country) K	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME N	
14. MOTHER'S MAIDEN NAME W		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. N		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
(A) Pulmonary Tuberculosis		
DUE TO		
ANTECEDENT CAUSES		
(B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....	23C. DATE SIGNED Feb. 9, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county)	(State)	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
Commissioner of Health		H. W. Mears
132		✓

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

0 50 1689
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) **CALVIN WORMACK**

2. DATE OF DEATH **February 19, 1950**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION
University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
216 S. Greene Street

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX **male**
6. COLOR OR RACE **colored**
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **u**

8. DATE OF BIRTH **U**
9. AGE (In years last birthday) **65**
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
K
10B. KIND OF BUSINESS OR INDUSTRY **K**

11. BIRTHPLACE (State or foreign country) **K**
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **N O**

14. MOTHER'S MAIDEN NAME **O**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. **N**

17. INFORMANT **N** ADDRESS

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Myocardial insufficiency**
DUE TO **Arteriosclerotic heart disease**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: **natural causes** ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE *[Signature]*

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED **Feb. 20, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

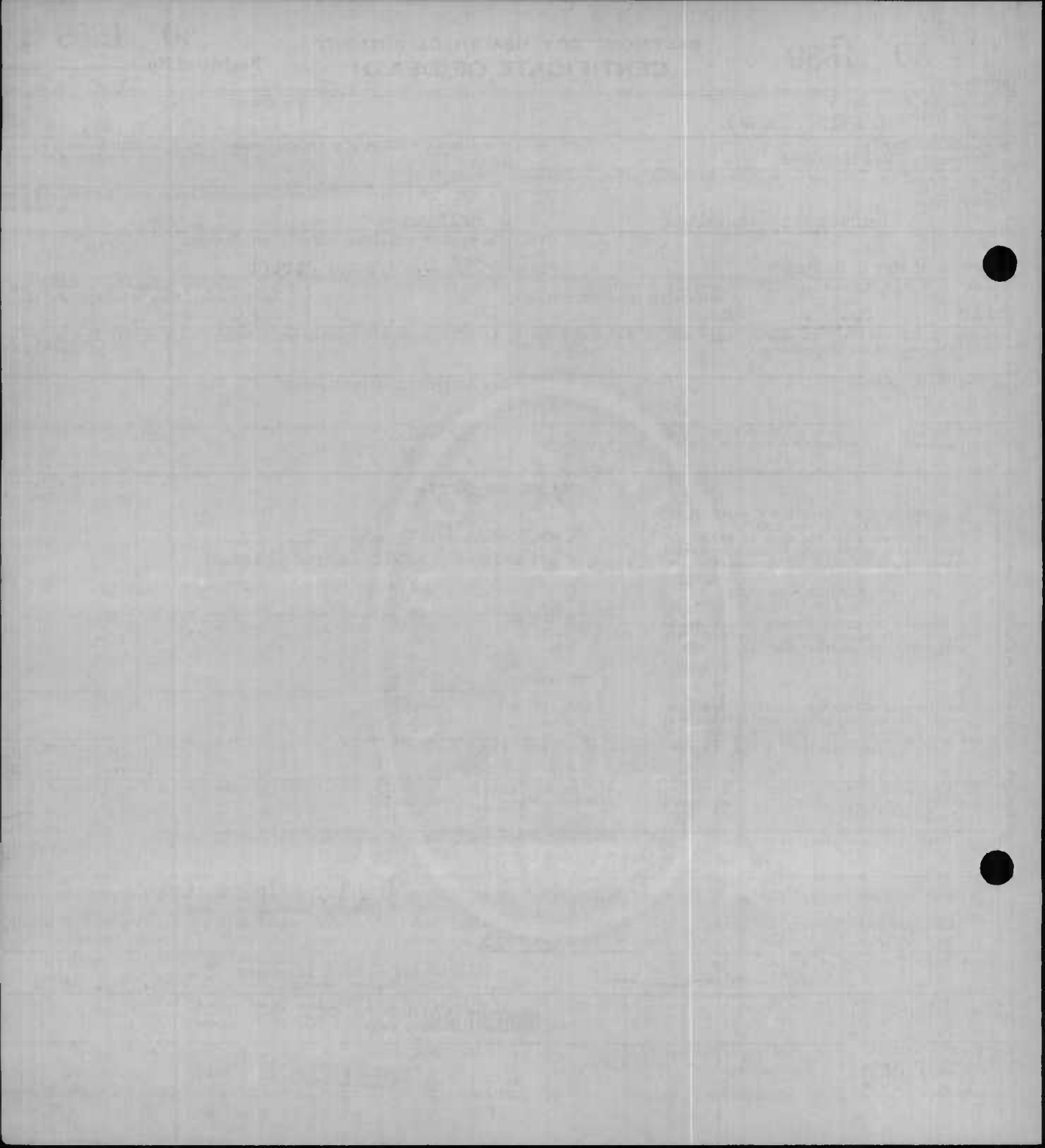
24C. NAME OF CEMETERY OR CREMATORY **UNIVERSITY MEDICAL SCHOOL** 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR **FEB 27 1950**

REGISTRAR'S SIGNATURE *[Signature]*

25. FUNERAL DIRECTOR **Commissioner of Health**

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1690**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) **HARRY GATTEN**

2. DATE OF DEATH **February 17, 1950**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE **Maryland**
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

Baltimore City Hospital

D. STREET ADDRESS (If rural, give location)
105 S. Spring Street

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX **male**

6. COLOR OR RACE **white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
U

8. DATE OF BIRTH
U

9. AGE (In years last birthday) **65**
If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY
K

11. BIRTHPLACE (State or foreign country)
K

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
N

14. MOTHER'S MAIDEN NAME
O

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
N

16. SOCIAL SECURITY NO.
N

17. INFORMANT
N

ADDRESS

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Arteriosclerotic cardiovascular disease
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER... ASSISTANT MEDICAL EXAMINER... MEDICAL INVESTIGATOR...
E. H. Royer
M.D.

23C. DATE SIGNED
Feb. 17, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)
UNIVERSITY MEDICAL SCHOOL FEB 27 1950

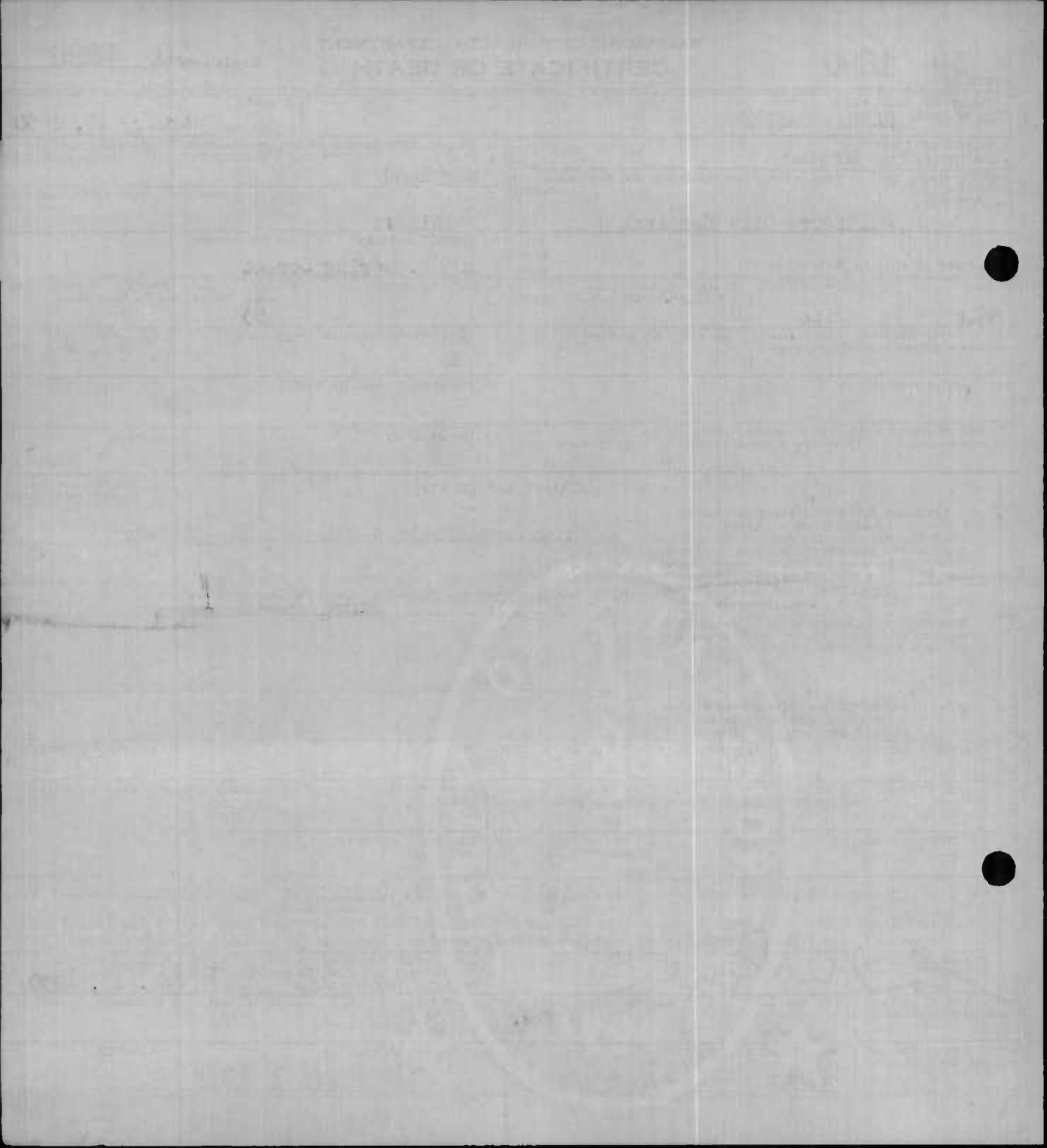
DATE RECEIVED BY LOCAL REGISTRAR
FEB 27 1950

REGISTRAR'S SIGNATURE
William Williams

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

1 50 1691
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JESUS (CHARLES) CHAS		2. DATE OF DEATH February 10, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1635 Thames Street	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) U	8. DATE OF BIRTH U
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) 65	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10B. KIND OF BUSINESS OR INDUSTRY K		11. BIRTHPLACE (State or foreign country) K	
13. FATHER'S NAME N O		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N	
17. INFORMANT N		ADDRESS	

MEDICAL CERTIFICATION

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Coronary artery disease DUE TO		
ANTECEDENT CAUSES (B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>R. S. Fisher</i>	23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR	23C. DATE SIGNED Feb. 10, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY
		24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL FEB 27 1950

DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950	REGISTRAR'S SIGNATURE <i>William Williams</i>	25. FUNERAL DIRECTOR <i>Commissioner of Health</i>	ADDRESS
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REPORT OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

300

50 1692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH331 50 1692
Registered No.

1. NAME OF DECEASED (Type or Print) Frederick (Fred) Scott		2. DATE OF DEATH Feb. 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 912 Appelton Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 16-04	
D. STREET ADDRESS (If rural, give location) 912 Appelton Street		E. LENGTH OF STAY IN BALTIMORE 10 Yrs.	
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 4th 1903
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 46
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Virginia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Unknown	
17. INFORMANT Esther L. Scott		ADDRESS 912 Appelton St.	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Cerebral Hemorrhage DUE TO		5 dyp.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Hypertension DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

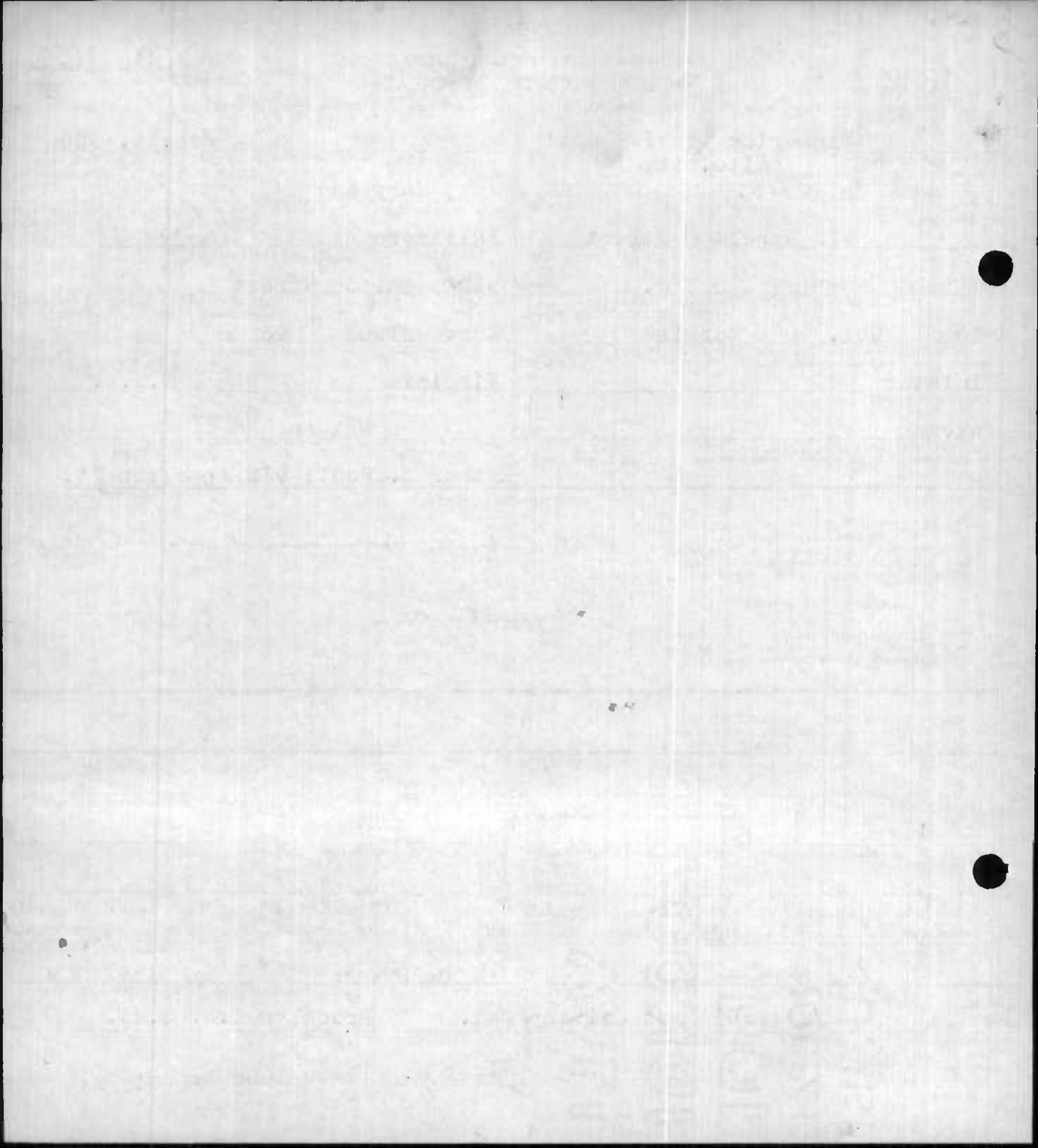
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **1-16-**, 19**50**, to **2-24-**, 19**50**, that I last saw the deceased alive on **2-23-**, 19**50**, and that death occurred at **7 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE W. H. Carver		23B. ADDRESS 611 N. Caroline St.		23C. DATE SIGNED 2-27-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/27/1950	24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.	24D. LOCATION (City, town, or county) (State) Brooklyn A.A. Co. Md.	
DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950		REGISTRAR'S SIGNATURE Elroy O. Wilson		25. FUNERAL DIRECTOR Elroy O. Wilson
ADDRESS 1000 Brantly Ave				

VS 150
V0894 195000001695 83a

MEDICAL CERTIFICATION



300
1693BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1693

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Elmer Kite</i>		2. DATE OF DEATH <i>February 23, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Baltimore</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Catonsville</i>	
6. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>5907 Carroll Ave.</i>	
7. SEX <i>male</i>	8. COLOR OR RACE <i>white</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	10. DATE OF BIRTH <i>June 29, 1893</i>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stone Mason</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
13. FATHER'S NAME <i>John Kite</i>		14. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <i>Cardiac Failure following operations for carcinoma of bladder</i>	INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	(B) DUE TO	(C)

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>2-10</i> , 1950, to <i>2-23</i> , 1950, that I last saw the deceased alive on <i>2-23</i> , 1950, and that death occurred at <i>8:30 P.M.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>JNP Johns</i>	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2/28/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Gord & Shepard</i>	24D. LOCATION (City, town, or county) (State) <i>Howard Co., Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 27 1950</i>	REGISTRAR'S SIGNATURE <i>William Williams</i>	25. FUNERAL DIRECTOR <i>Brace & Son</i>	ADDRESS <i>Catonsville</i>

VS 150

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1693

52B

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

City of _____

On this _____ day of _____

512
10 1694BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH450.0 50 1694
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROSE SIMPSON

2. DATE
OF
DEATH

2-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1701 No Ellanor St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

(before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Templatt Home

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4106 Garrison Boulevard

C. Length of stay in Baltimore

50

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

9. AGE (in years,

last birthday)

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

56

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

maid

10B. KIND OF BUSINESS OR INDUSTRY

Housework

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lark

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Albert Simpson 4106 Garrison Blvd

CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Broncho - pneumonia

2 day 5

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Involuntional psychosis

1 year

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

generalized arterio sclerosis

20 years?

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Nov 12 1949 to Feb 26, 1950, that I last saw the deceased alive on Feb 26, 1950, and that death occurred at 6 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Jack Cohen

M. D.

23B. ADDRESS

1804 Eutaw Place

23C. DATE SIGNED

2/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2-27-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Serung Hill

24D. LOCATION (City, town, or county)

Balto Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Jack Lewis

ADDRESS

2100 Eutaw Pl

VS 150

52086

107

MEDICAL CERTIFICATION

Cohen
1804 Antony

240
1695

GASLOW
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1695
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Max Gaslow</i>		2. DATE OF DEATH <i>2-26-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Senar</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>3400 Taney Road</i>		E. LENGTH OF STAY IN BALTIMORE <i>50</i> Yrs. <i>58</i> Mos. <i>Days</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Office Equipment</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Sammy</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Molly Gaslow</i>		ADDRESS <i>3400 Taney Road</i>	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>(A) Hypertensive Cardiomyopathy Senar</i>		
DUE TO		
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>(B) Uremia</i>		
DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *2/10*, 1950, to *2/26*, 1950, that I last saw the deceased alive on *2/25*, 1950, and that death occurred at *10:55* A.M., from the causes and on the date stated above.

23A. SIGNATURE <i>Jerome Gaber</i>	M. D.	23B. ADDRESS <i>Senar Harp</i>	23C. DATE SIGNED <i>2/26/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2-27-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Hebrew Rosedale</i>	24D. LOCATION (City, town, or county) (State) <i>Balto md</i>

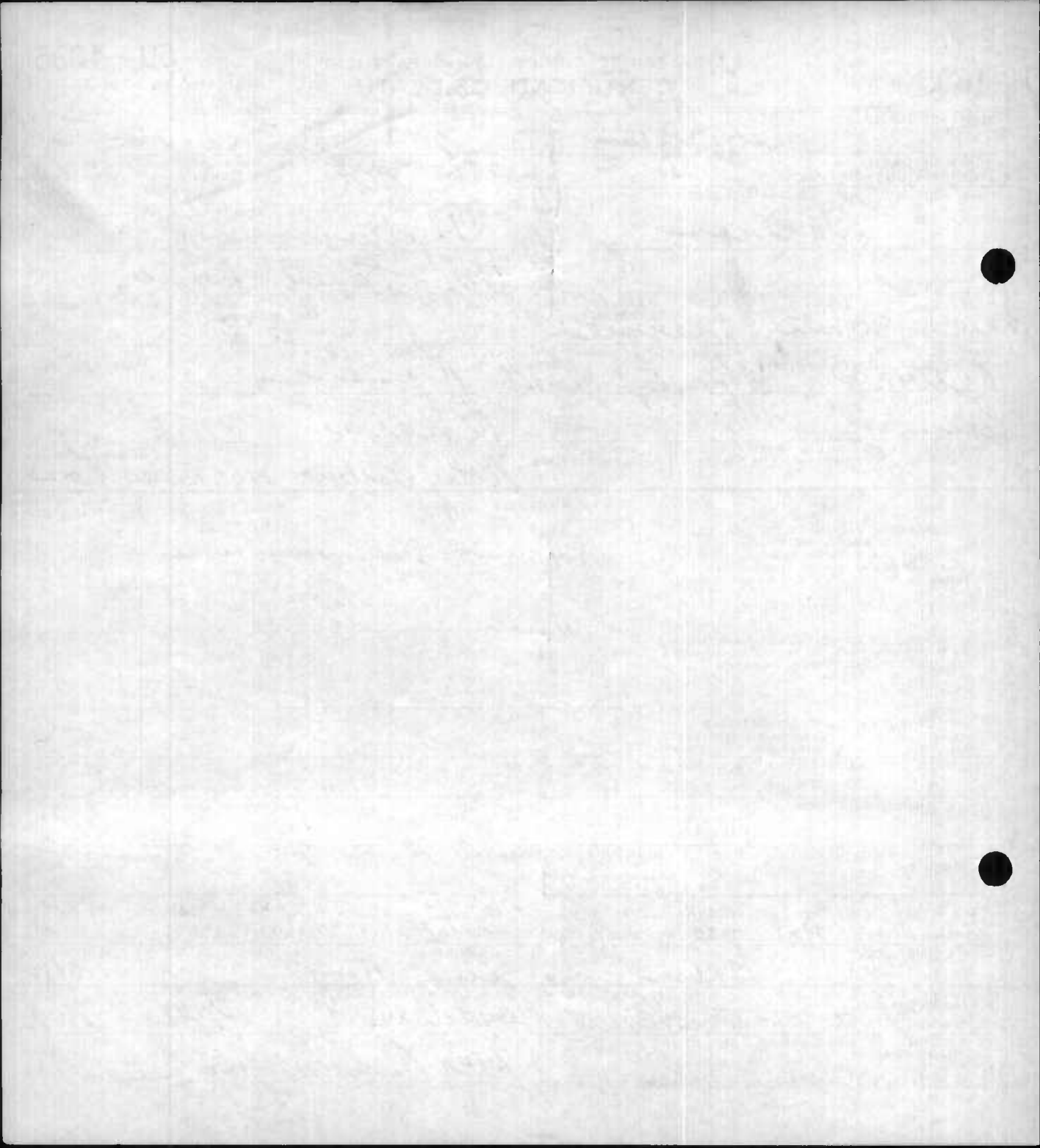
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 27 1950</i>	REGISTRAR'S SIGNATURE <i>William Williams</i>	25. FUNERAL DIRECTOR <i>Jack Lewis</i>	ADDRESS <i>2100 Eutaw Pl</i>
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MEDICAL CERTIFICATION



613
50 1696

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50.0 50 1696
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Rebecca Mirovitz</i>			2. DATE OF DEATH <i>2-26-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>md</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1627 Ruston Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore 15-03</i>		
C. Length of stay in Baltimore <i>60</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>1627 Ruston Ave</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH	9. AGE (In years last birthday) <i>84</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Russia</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Samuel</i>			14. MOTHER'S MAIDEN NAME <i>Etta</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Etta Mirovitz</i>			ADDRESS <i>1627 Ruston Ave</i>		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>(A) Malnutrition</i>		<i>2 mos</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST, <i>(B)</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT. <i>(C) Arteriosclerosis</i>		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *March*, 1949 to *Feb 26*, 1950 that I last saw the deceased alive on *Feb 26*, 1950, and that death occurred at *5:30 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Coral Gordon</i>	23B. ADDRESS <i>300 E. North Ave</i>	23C. DATE SIGNED <i>2-26-50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2-27-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Rosevale</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 27 1950</i>	REGISTRAR'S SIGNATURE <i>John L. ...</i>	25. FUNERAL DIRECTOR <i>2100 E. ...</i>	ADDRESS <i>...</i>
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00001699 97

DEPARTMENT OF HEALTH
UNITED STATES OF AMERICA

DATE OF BIRTH
PLACE OF BIRTH

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340
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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1697
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) MILTON LEWIS (M.) WHEATLEY		2. DATE OF DEATH Feb 26 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 2322 Cellox Ave		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE 3221 Woodland Ave B. COUNTY 27-16			
B. FULL NAME OF HOSPITAL OR INSTITUTION (Dr. Fachman's office)		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/18/19	9. AGE (In years last birthday) 70	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Ligon & Ligon		11. BIRTHPLACE (State or foreign country) Dorchester Co. Md.	
13. FATHER'S NAME Thomas Wheatley		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Mollie Marshall	
		17. INFORMANT Carville D. Duncan		ADDRESS 331 N. DESE Glenburnie	

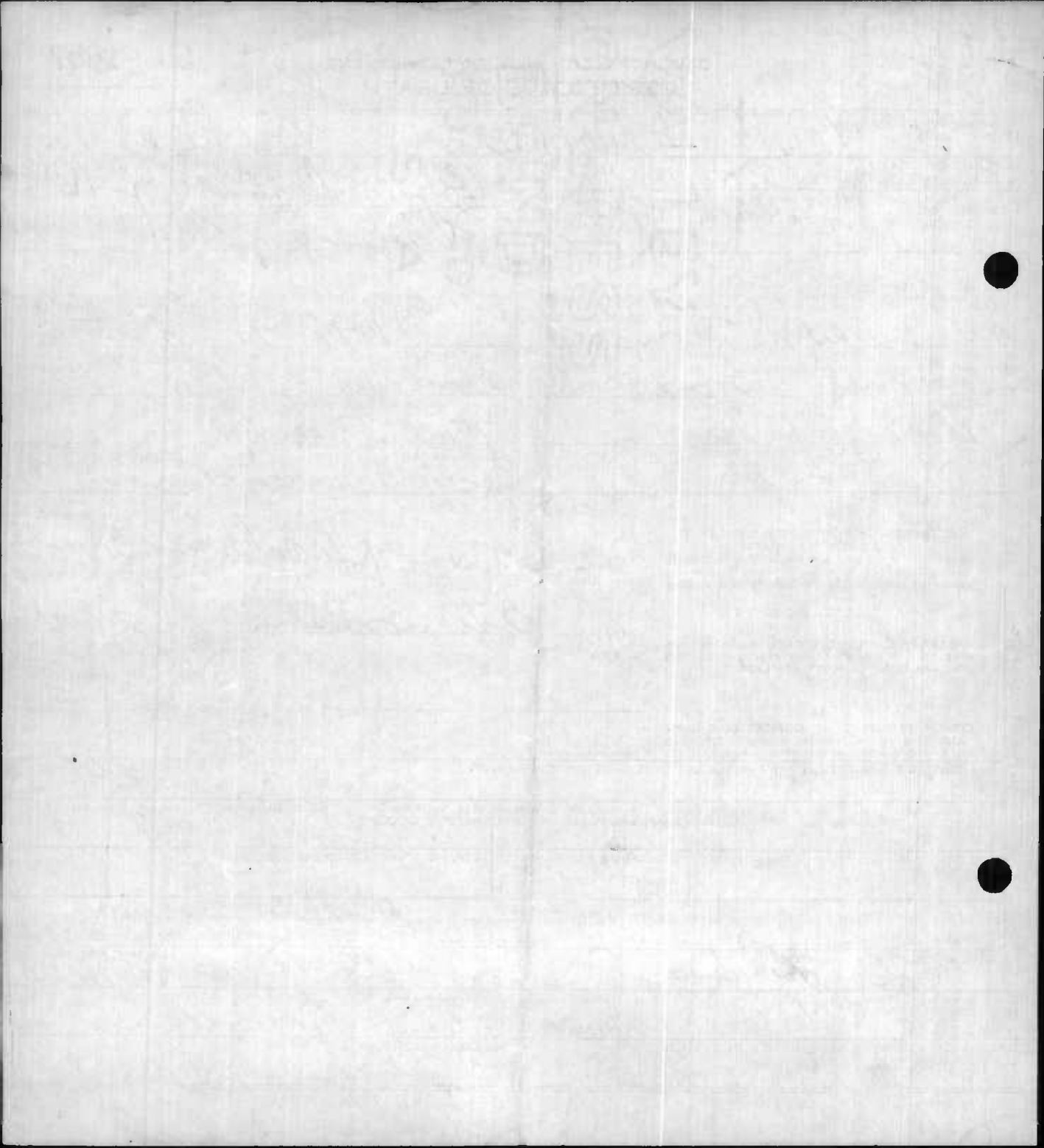
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis		3 months
(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. arteriosclerosis		5 or 7
(B) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
(C)		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 10 , 19 50 , to Feb 26 , 19 50 , that I last saw the deceased alive on 19 and that death occurred at 10:45 P.M. , from the causes and on the date stated above.					
23A. SIGNATURE Dr. Fachman		23B. ADDRESS 2322 Cellox Ave		23C. DATE SIGNED Feb 26 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 13/1/50		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge	
24D. LOCATION (City, town, or county) (State) Pikesville Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950		24F. REGISTRAR'S SIGNATURE Wm. Cook Inc.	
24G. FUNERAL DIRECTOR Wm. Cook Inc.		24H. ADDRESS 1217 St. Paul St.			

MEDICAL CERTIFICATION

316 V9

94a



362
1698BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH51 50 1698
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Beulah Lee Witters</i>		2. DATE OF DEATH <i>2/25/1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1804 Barclay St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 12-05</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1804 Barclay St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>4/6/1875</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	9. AGE (In years last birthday) <i>74</i>
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas D. Witters</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte E. Nicol</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Miss Lotta M. Witters</i>		ADDRESS <i>1804 Barclay St.</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of stomach</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 mos</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Cachexia</i>		<i>1 mo</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

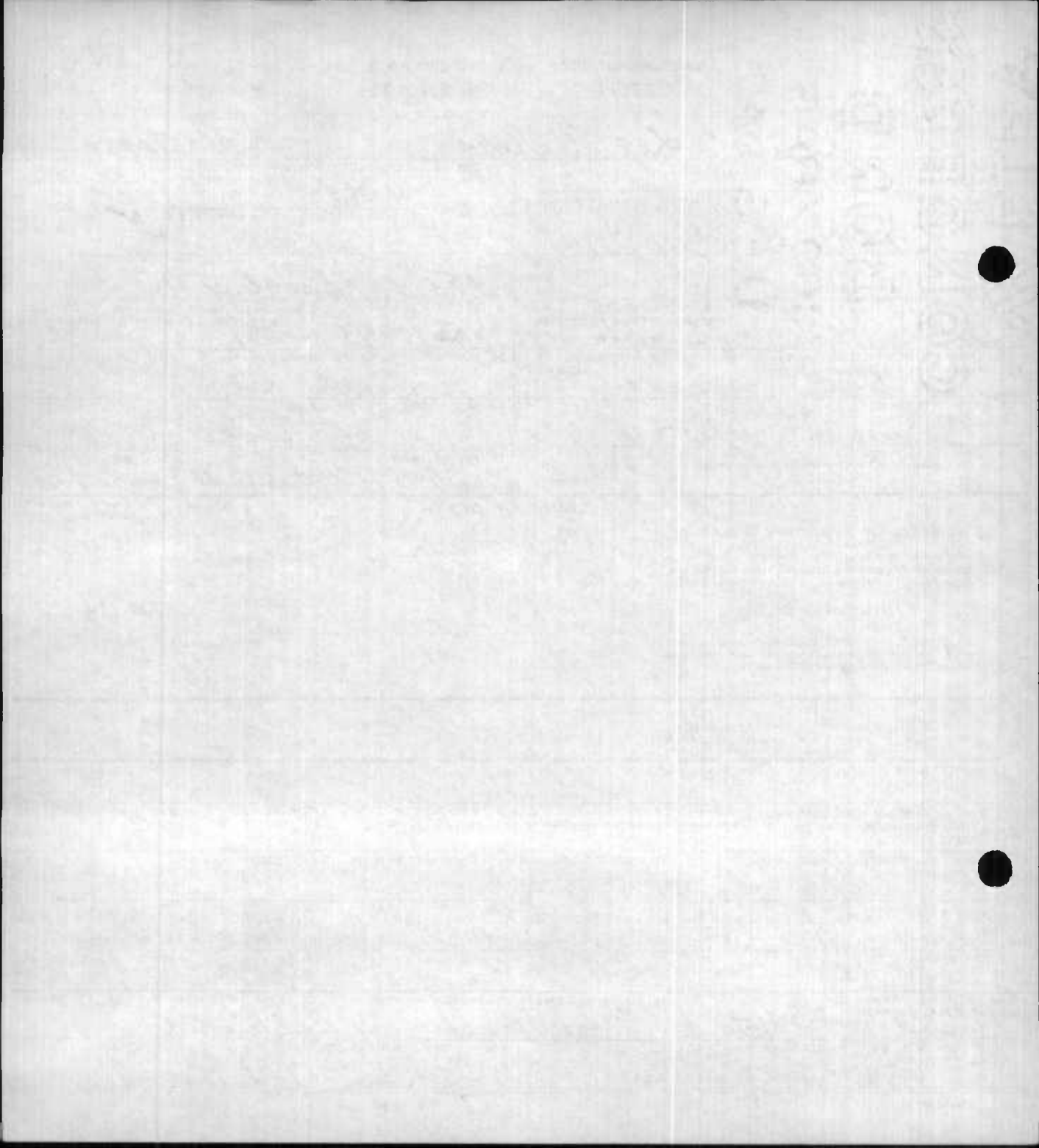
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *Oct 15, 1949* to *July 25, 1950*, that I last saw the deceased alive on *2/24, 1950* and that death occurred at *12:45 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>George A. Hardin</i>		23B. ADDRESS <i>323 Medals Bldg</i>		23C. DATE SIGNED <i>2/26/50</i>	
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>2/28/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
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DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 27 1950</i>		REGISTRAR'S SIGNATURE <i>William J. Williams, Jr.</i>		25. FUNERAL DIRECTOR <i>Wm. J. Williams, Jr.</i>		ADDRESS <i>1217 St. Paul St.</i>	
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263
50 1699BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH3770 50 1699
Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOSEPH

DOUGHERTY

2. DATE

OF

DEATH

February 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1202 Bayard Street

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

4/18/1907

9. AGE (In years last birthday)

42

If Under 1 Year

Months Days

If Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sanitor

10B. KIND OF BUSINESS OR INDUSTRY

Stewart & Co

11. BIRTHPLACE (State or foreign country)

Balto. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

(Unknown)

Dougherty

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

U. S. #2

16. SOCIAL SECURITY NO.

117-167147

17. INFORMANT

ADDRESS

Joseph Dougherty 222 S. Broadway

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Acute alcoholism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

E. L. Royer

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

Feb. 24, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/28/50

24C. NAME OF CEMETERY OR CREMATORY

U.S. National

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

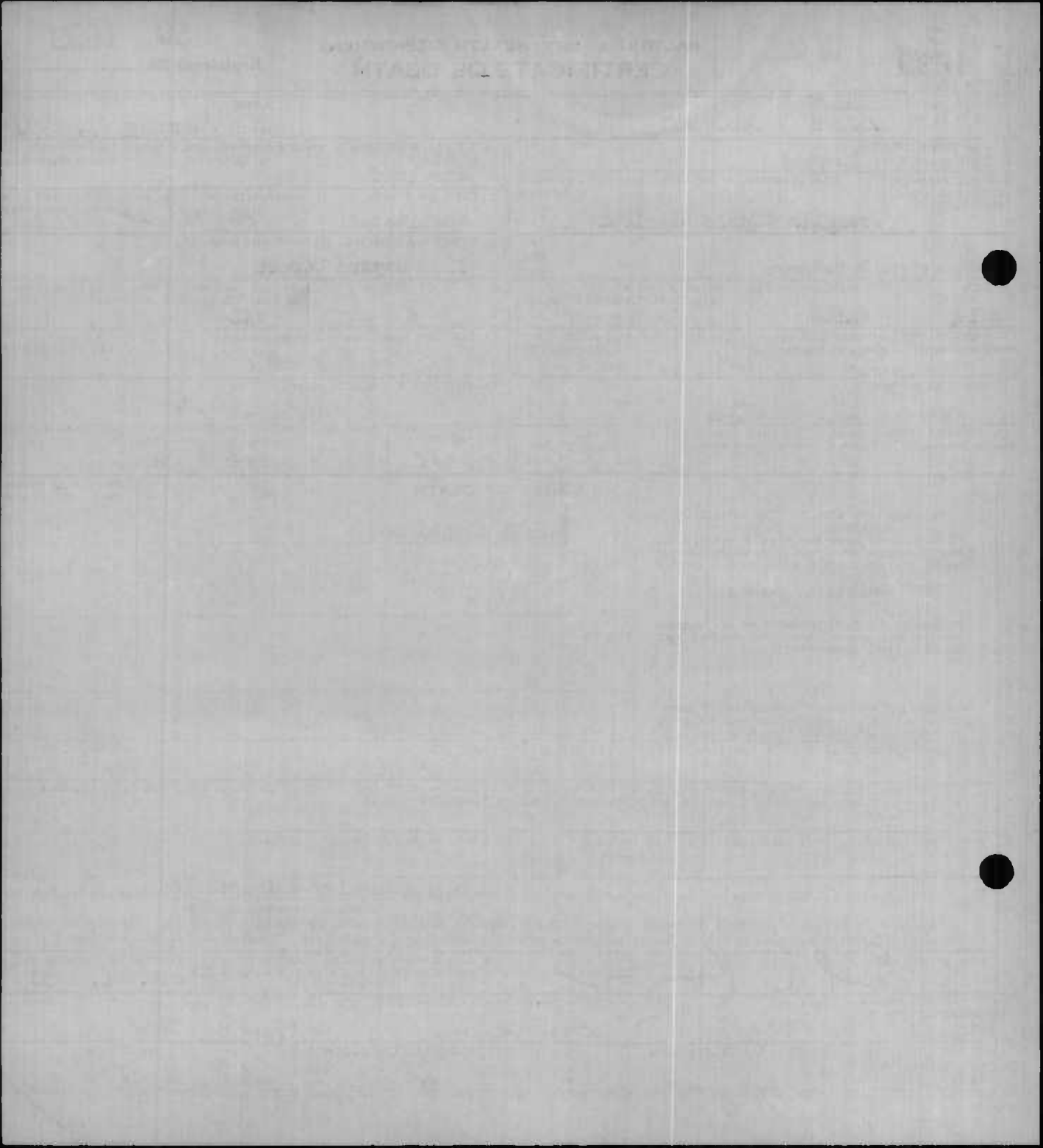
FEB 27 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

1217 St. Paul St.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1700
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN H. E. McKEE

2. DATE
OF
DEATH

February 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

707 W. Fayette Street

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

male

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

7/16/1948

9. AGE (In years
last birthday)10 Under 1 Year
Months: Days

19

11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Edward McKee

14. MOTHER'S MAIDEN NAME

Rebecca Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Edward McKee 707 W. Fayette St.

18. 391.2

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Septicemia due to Beta hemolytic

Strep. streptococci due to bilateral otitis media

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

R. S. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒ ASSISTANT MEDICAL EXAMINER.....☐
MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED
Feb. 25, 195024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

2/27/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peter's

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Cook Inc. 1217 St. Paul St.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SEX

AGE

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

523
1701

Demukaitis

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH470.0 50 1701
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Demukaitis, Ida.

2. DATE
OF
DEATH

2-24-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Franklin Square Hospital

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Edward Luckman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

(Yes, oo or ooowoo)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Balt.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

19-04

D. STREET ADDRESS (If rural, give location)

1846 W. Pratt St.

8. DATE OF BIRTH

4-1-1867

9. AGE (In years last birthday)

82

If Under 1 Year Months: Days Hours: Min.

10 34

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Anna Bittorf

17. INFORMANT

ADDRESS

Marion Rodin

3034 W. North Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Cerebral Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Arterio Sclerotic Heart Disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR
FEB 27 1950

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

47-48 E. McK. 1217 St. Paul St.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

1702

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Mary R. Hall

2. DATE
OF
DEATH

Feb. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 619 Archer St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

619 Archer St.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
Balto. 21-02

D. STREET ADDRESS (If rural, give location)

619 Archer St.

Length of stay in Baltimore

50 Yrs.

Yrs.
Mos.
Days

5. SEX

F.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

Mar. 12, 1872

9. AGE (In years last birthday)

77 78

10 Under 1 Year Months: Days: 11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Anne Arundel County

12. CITIZEN OF WHAT COUNTRY?
U.S.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Leonard Curtis 619 Archer St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Occlusion

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardio - Vascular Disease

(C)

Arteriosclerosis

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 11-9 1946, to 2-24, 1950, that I last saw the deceased alive on 2-23, 1950, and that death occurred at 1A m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John P. Urquely Jr.

M. D.

1227 Washington Blvd.

2-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial.

24B. DATE

Feb. 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Arbutus Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

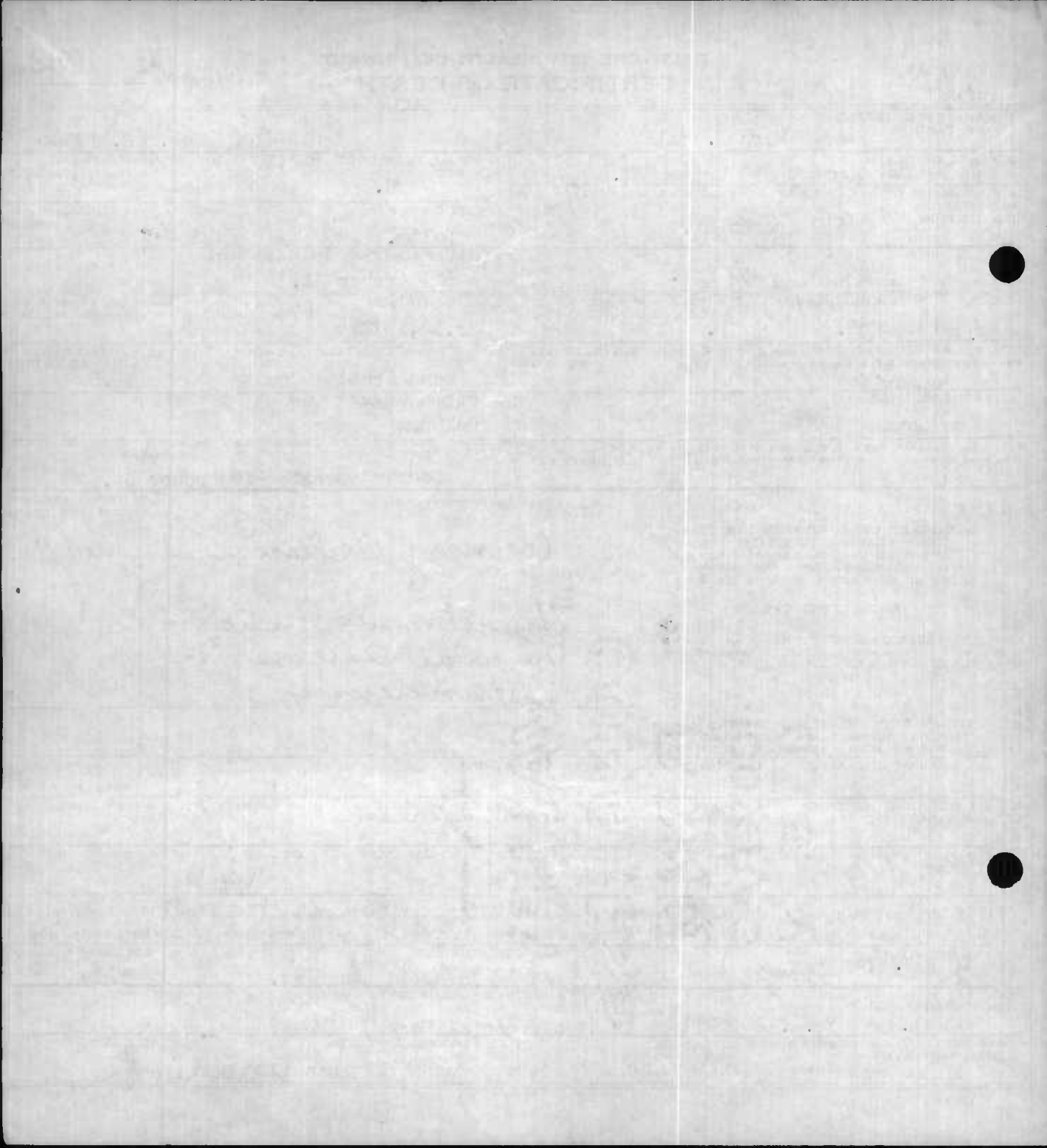
25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

William M. Williams

Joseph L. Russ 1200 McCulloh St



Certificate corrected 3-3-50

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 5711 50 1703

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Oliver Burley Hall

Ollie Hall

2. DATE
OF
DEATH

Feb 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

619 Archer St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN

Balto.

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

619 Archer St.

5. SEX

M.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

W.

8. DATE OF BIRTH

Jan. 12 1884

9. AGE (In years,
last birthday)

66

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John Hall

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, oo or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Annie Speed 619 Archer St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) *Gastroenteritis, cause
undetermined*

3 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C) *Paralysis right side of body 63 years*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., io or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-20 1948 to 2-26, 1950, that I last saw the
deceased alive on 2-23, 1950, and that death occurred at 7 p. m., from the causes and on the date stated above.

23A. SIGNATURE

John P. Unbeck, Jr.

M. D.

23B. ADDRESS

1227 Washington B lvd.

23C. DATE SIGNED

27 Feb. 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 1 1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county)

Arbutus Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William J. Williams, M.D.

25. FUNERAL DIRECTOR

Joseph L. Russ

ADDRESS

1200 McCulloh St.

VS 150

988991 7500001706

1200

Contact to the Department of Health, Baltimore City, Maryland, for a copy of the certificate of death, please refer to the number of the certificate of death, and the name of the deceased.

La-3361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 1704

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James Burris

2. DATE

OF

DEATH

2-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Baltimore City Hospitals

Yrs.

Mos.

Days

Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Crownsville Hospital

D. STREET ADDRESS (If rural, give location)

Crownsville Hospital

9. AGE (In years last birthday)

57

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plasterer

10B. KIND OF BUSINESS OR INDUSTRY

Repair Houses

8. DATE OF BIRTH

?

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

ADDRESS 4940

Records*Balto. City Hospitals Eastern Ave.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Anaesthetic Death

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

CERTIFICATION APPROVED BY

St. J. McCafferty, M.D.
for: C.J. Lubinski, M.D.

CHIEF OR ASST. MEDICAL EXAMINER

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Lung Abscess

19A. DATE OF OPERATION

2-24-50

19B. MAJOR FINDINGS OF OPERATION

Lung Abscess

20. AUTOPSY?

YES ☒NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Hospital

21C. WHERE DID (If in Baltimore City, give exact location)

4940 Eastern Avenue--Balto. City Hosp.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

2-24-50

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingestion of cyclopropane & COE Anes.

22. I hereby certify that I attended the deceased from 1-28, 1950 to 2-24, 1950, that I last saw the deceased alive on 2-24, 1950, and that death occurred at 10:00 A. M. from the causes and on the date stated above.

23A. SIGNATURE

J.S. Rogers

M. D.

23B. ADDRESS

4940 Eastern Avenue

23C. DATE SIGNED

2-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

2/27/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county)

A. A. County, Md

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

J. S. Rogers

Joseph S. Rogers

1304 N. Central Ave

VS 150

346 V9

TO BE APPROVED BY CHIEF MEDICAL EXAMINER 707

1147

0-2-10

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1705

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1705

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mag. Meyer

2. DATE
OF
DEATH

Feb 24-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF

(If not in hospital or institution, give street address or location)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

HOSPITAL OR

INSTITUTION

D. STREET ADDRESS (If rural, give location)

E. Length of stay in Baltimore

72 yrs

Yrs.

Mos.

Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years-
last birthday)

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Meyer

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

C. Benglein 1035 Hanover St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Influenza
Acetosis - Chronic Myocarditis

Feb-20-23

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Feb 5, 1950, to Feb 23, 1950, that I last saw the
deceased alive on Feb 23, 1950, and that death occurred at 1030 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

William J. Williams

B. C. Haele 1000 S Paca St.

195000001700

23B

Q make
2900 Hammer Bits

220
50 1706
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1706
Registered No.

1. NAME OF DECEASED (Type or Print) <u>Walter Filmore Hughes</u>			2. DATE OF DEATH <u>2-24-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland 1606 Saint Paul St.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
D. STREET ADDRESS (If rural, give location) <u>1606 St. Paul St.</u>			E. DATE OF BIRTH <u>11-26-07</u>		
F. AGE (In years last birthday) <u>42</u>			G. Under 1 Year Months: Days		
H. Under 24 Hours Hours: Min.			I. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		
J. CITIZEN OF WHAT COUNTRY?			K. FATHER'S NAME <u>Thomas Calvin Hughes</u>		
L. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>			M. SOCIAL SECURITY NO. <u>218-14-2834</u>		
N. INTERIM ADDRESS			O. MOTHER'S MAIDEN NAME <u>Anna Hickory</u>		
P. LENGTH OF STAY IN BALTIMORE <u>40 years</u>			Q. DATE OF OPERATION		
R. SEX <u>Male</u>			S. COLOR OR RACE <u>White</u>		
T. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			U. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) <u>Merchant Seaman</u>		
V. KIND OF BUSINESS OR INDUSTRY <u>Maritime Comm.</u>			W. INTERIM ADDRESS		

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		one year
(A) PULMONARY TUBERCULOSIS FAR ADVANCED		
DUE TO		
ANTECEDENT CAUSES		2 yrs.
(B) CIRRHOSIS OF LIVER		2 mos.
DUE TO		
(C) INANITION		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1949, to Feb. 24, 1950, that I last saw the deceased alive on Feb. 23, 1950 and that death occurred at 10:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE <u>E. Ellsworth Cook</u> M. D.	23B. ADDRESS <u>2431 Maryland Ave.</u>	23C. DATE SIGNED <u>2/27/50</u>
---	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>2-28-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
--	-----------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR <u>FEB 27 1950</u>	REGISTRAR'S SIGNATURE <u>Walter Williams</u>	25. FUNERAL DIRECTOR <u>E. Ellsworth Cook</u>	ADDRESS <u>5118 Gwynn Oak Ave.</u>
--	---	--	---------------------------------------

Ed-

Respectfully,
Ed

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1707

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD H. THOMSON		2. DATE OF DEATH 2-26-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland 2035 Wheeler		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION at home		C. CITY OR TOWN Balto. City - 15-04	
6. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 2035 Wheeler Ave	
7. SEX Male	8. COLOR OR RACE White	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	10. DATE OF BIRTH Aug-1-1898
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		12. KIND OF BUSINESS OR INDUSTRY Brokerage	
13. FATHER'S NAME Edw. H. Thomson		14. MOTHER'S MAIDEN NAME Anna - ? -	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 212-07-7592	
17. INFORMANT Valerie D. Dixon		ADDRESS # 2035 Wheeler	

CAUSE OF DEATH

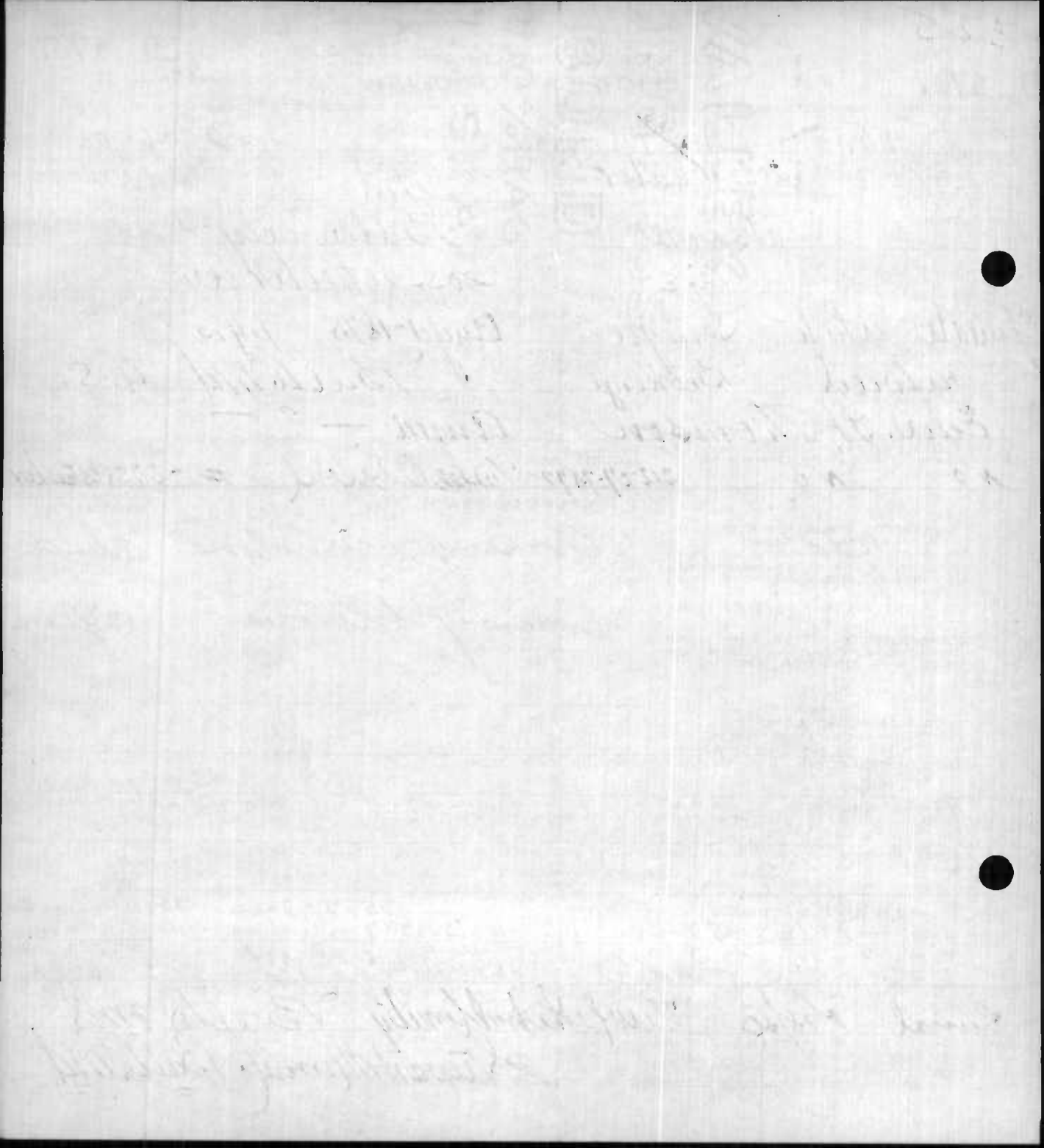
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 hour
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Coronary Sclerosis		12 years
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1935 to 2-26-1950**, that I last saw the deceased alive on **2-16-1950**, and that death occurred at **12:30 PM** from the causes and on the date stated above.

23A. SIGNATURE **C. W. Peake** M. D. 23B. ADDRESS **4508 Maryland Rd.** 23C. DATE SIGNED **2-26-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/28/50	24C. NAME OF CEMETERY OR CREMATOR Newkirk Cemetery	24D. LOCATION (City, town, or county) (State) Balto. Md.
DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950		25. FUNERAL DIRECTOR Stewart Moreno	
REGISTRAR'S SIGNATURE William H. Williams		ADDRESS Balto. Md.	



6300
50 1708

135581

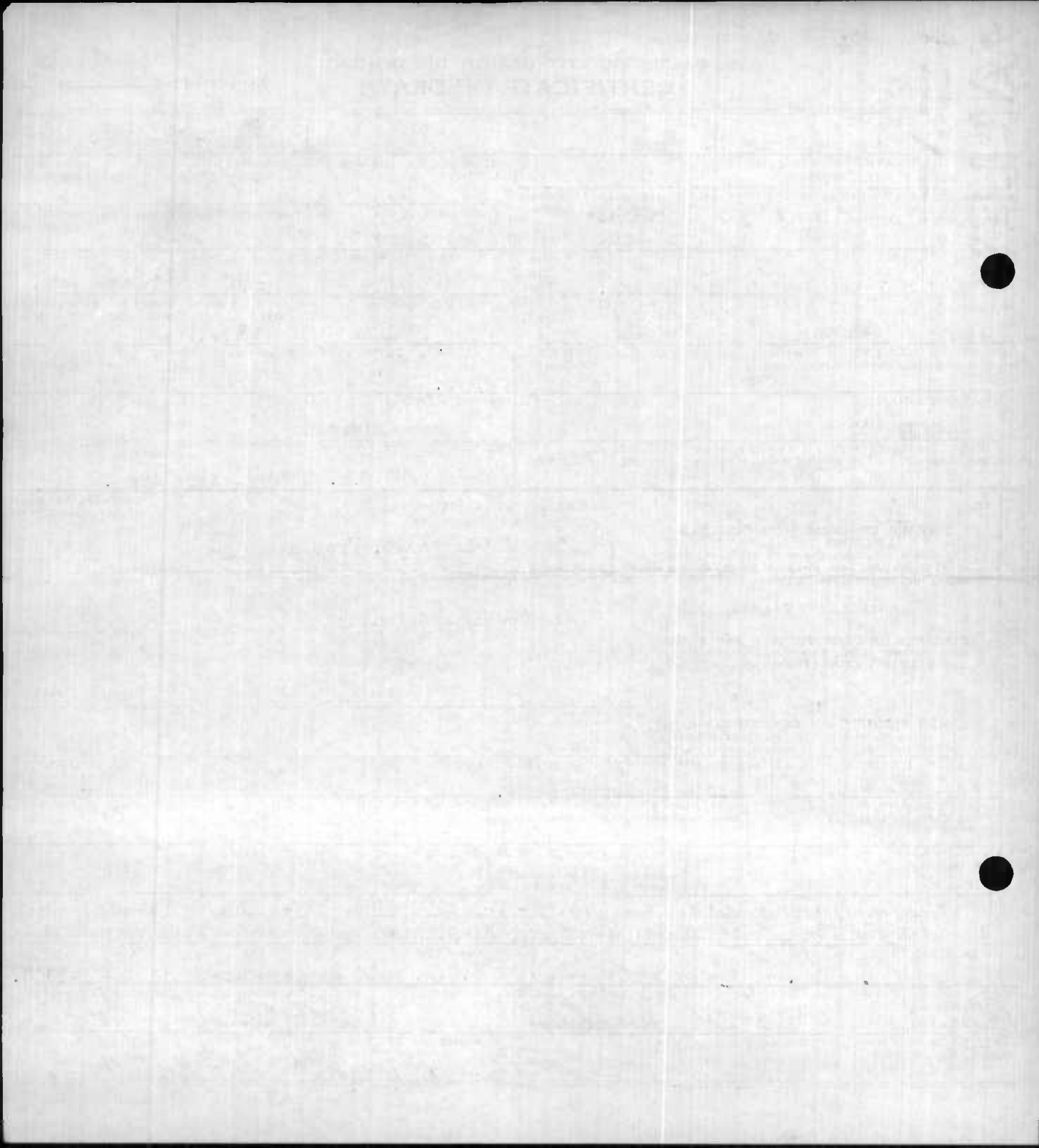
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

584 50 1708
Registered No.

1. NAME OF DECEASED (Type or Print) Henry M. Ward		2. DATE OF DEATH 2-26-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 E. Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-01	
Length of stay in Baltimore 30 Yrs. Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) Salvation Army -923 S. Fremont Ave.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 13 1866
9. AGE (In years last birthday) 83 Yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Ward		14. MOTHER'S MAIDEN NAME Sarah Caldwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records B.C.H. 4940 E. Eastern Ave.		ADDRESS	

18. CAUSE OF DEATH	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Portal Cirrhosis, Uremia (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Common Duct Calculus (B) DUE TO		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION Feb. 12- Feb. 25		19B. MAJOR FINDINGS OF OPERATION Stone in Common Duct.		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-7-1950 to 2-26-1950 , that I last saw the deceased alive on 2-26-1950 and that death occurred at 9.20 AM , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS B.C.H. 4940 Eastern Ave.		23C. DATE SIGNED 2-26-1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-28-50		24C. NAME OF CEMETERY OR CREMATORY Western	
24D. LOCATION (City, town, or county) (State) Baltimore - Md.		24E. FUNERAL DIRECTOR Stewart & McQueen		24F. ADDRESS 108 W. North Ave.	
DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>		24G. ADDRESS	



BIRTH NO. 49-19584		2. DATE OF DEATH 2-25-50	
1. NAME OF DECEASED (Type or Print) DEBORAH TOYER		3. PLACE OF DEATH: A. Baltimore City, Maryland UNIV. HOSP	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. OF MD. HOSP.		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MD B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-01		D. STREET ADDRESS (If rural, give location) 1661 KESLER ST.	
5. SEX F		6. COLOR OR RACE C	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S		8. DATE OF BIRTH 9-7-49	
9. AGE (In years last birthday) 6		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY CHLD	
11. BIRTHPLACE (State or foreign country) Balto. Md		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JOSEPH HARVEY		14. MOTHER'S MAIDEN NAME ANABEL TOYER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DIARRHEA	
DUE TO		DEHYDRATION & ACIDOSIS	
II ANTECEDENT CAUSES		(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO	
(C)			
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-24, 1950, to 2-25, 1950, that I last saw the deceased alive on 2-25, 1950, and that death occurred at 4:00 A.M., from the causes and on the date stated above.			
23A. SIGNATURE John W. Kelson M. D.		23B. ADDRESS UNIV. HOSP	
23C. DATE SIGNED 2-25-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2/1/50	
24C. NAME OF CEMETERY OR CREMATORY St Peters		24D. LOCATION (City, town or county) (State) Balto. Md	
25. FUNERAL DIRECTOR Reg. H. Kelson 1303 Resolman		ADDRESS	

FEB 27 1950

VS-150

119a

ST

1000000

1000000

1000000

1000000

1000000

F-653

50 1710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1710

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HELEN A. FRANTZ

2. DATE
OF
DEATH

Feb. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

717 Lennox St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

717 Lennox St.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 19, 1903

9. AGE (In years
last birthday)

46

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Hugh P. Price

14. MOTHER'S MAIDEN NAME

Eliza Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT ADDRESS
Mr. Douglas S. Frantz 717 Lennox St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

B. Adeno carcinoma R. Breast.

DUE TO

1 1/2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

A metastasis to Lung

2 wks.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

8/5/48

19B. MAJOR FINDINGS OF OPERATION

adeno carcinoma

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/29, 1948, to 2/26, 1950 that I last saw the
deceased alive on 2/26, 1950, and that death occurred at 11 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

2200 N. Charles St.

2/27/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/1/50

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

WM. J. TICKNER & SONS Balto., Md.

B-420

50 1711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Dr. H. H. H. H. H.
50 1711
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Helen Young Blaise

2. DATE
OF
DEATH

Feb. 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1831 Mulberry St.

C. Length of stay in Baltimore

61 yrs.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Dec. 24, 1888

9. AGE (In years
last birthday)

61

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

13. FATHER'S NAME

Edward Shipley

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA.

14. MOTHER'S MAIDEN NAME

Catherine Woodland

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

William Young 205 St. Albans St.
Roxbury 19, Mass.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-1-1950 to 2-24-1950 that I last saw the
deceased alive on 2-24-1950 and that death occurred at 1 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

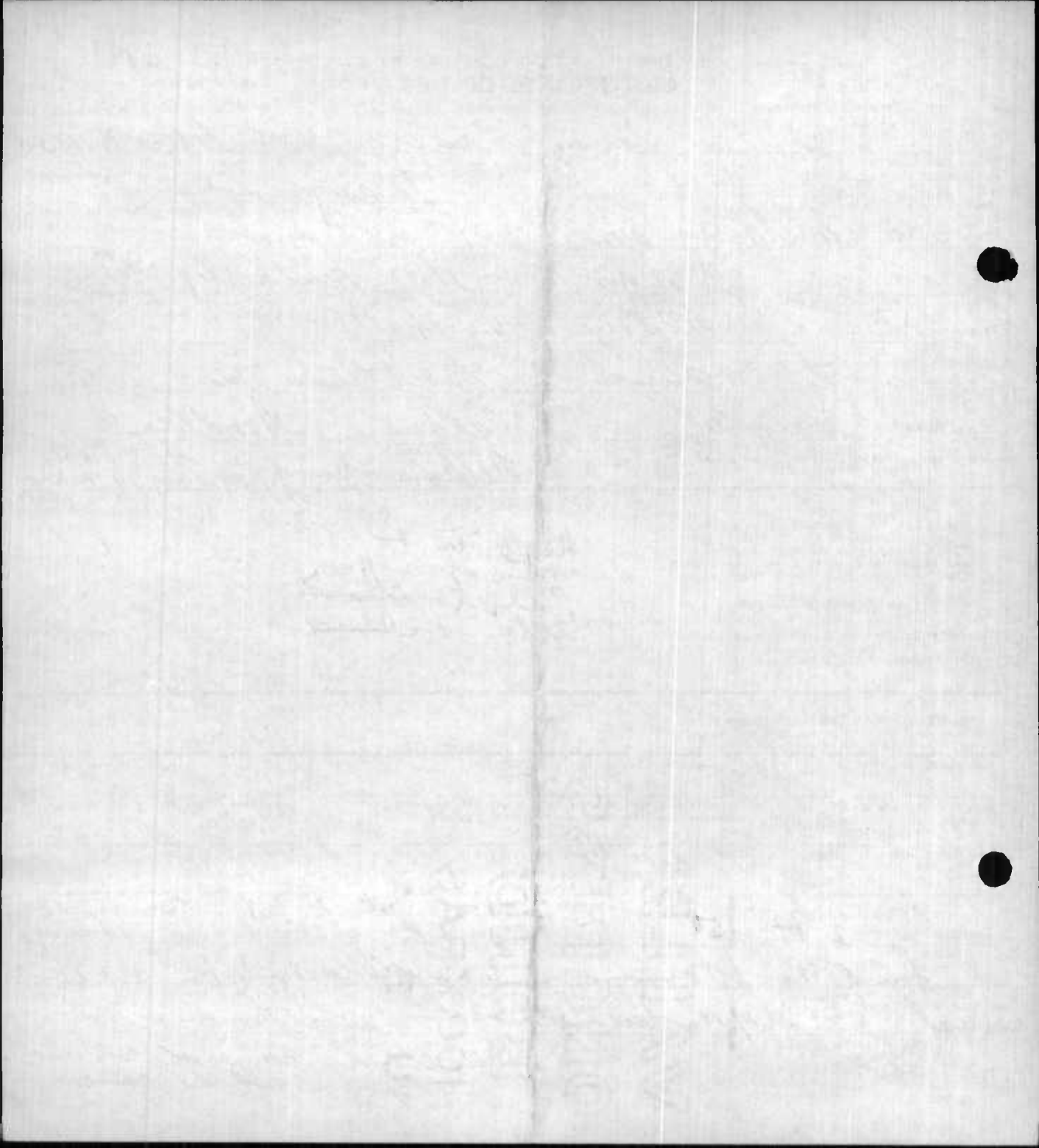
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

Holland Funeral Home
1601 W. 11th St. S.W.
92a



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1712
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ADDISON

JOHNSON

2. DATE
OF
DEATH

February 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

1415 W. Lafayette Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1514 W. Lafayette Avenue

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 2, 1875

9. AGE (In years
last birthday)

74

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR
INDUSTRY

Private family

13. FATHER'S NAME

James Johnson

11. BIRTHPLACE (State or foreign country)

Anne Arundel Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Frances Curry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Alice W. Johnson

ADDRESS 1415
W. Lafayette

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Myocardial insufficiency

DUE TO arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R S Fisher

23B. CHIEF MEDICAL EXAMINER.....☒
ASSISTANT MEDICAL EXAMINER.....☐
M.D. MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED
2-25-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

2/28/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Holland Funeral Home

ADDRESS

1631 Druid Hill Ave.

650
1713BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH5400 50 1713
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Croncy

2. DATE
OF
DEATH

FEB 25 1950

3. PLACE OF DEATH:
A. Baltimore City, MarylandB. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
before admission)
A. STATE

Md

B. COUNTY

C. CITY OR TOWN, (If outside corporate limits, write RURAL and give
township)

Baltimore

6-02

D. STREET ADDRESS (If rural, give location)

412 N. Belmord Ave.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Stage Hand

10B. KIND OF BUSINESS OR
INDUSTRY

Theatre

13. FATHER'S NAME

John Croncy

8. DATE OF BIRTH

3-3-81

9. AGE (In years
last birthday)

68

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Minnie Wahn

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

216-01-0172

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Gastrointestinal Hemorrh.
DUE TO huge Due to Bleeding
Peptic Ulcer

14 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-23-1950, to 2-25-1950, that I last saw the
deceased alive on 2-25-1950, and that death occurred at 3:10 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Robert C. Hartmann M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

2/25/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Feb 28/50

24C. NAME OF CEMETERY OR CREMATORY

Schurck's Lane Baltimore

24D. LOCATION (City, town, or county)

Baltimore

(State)

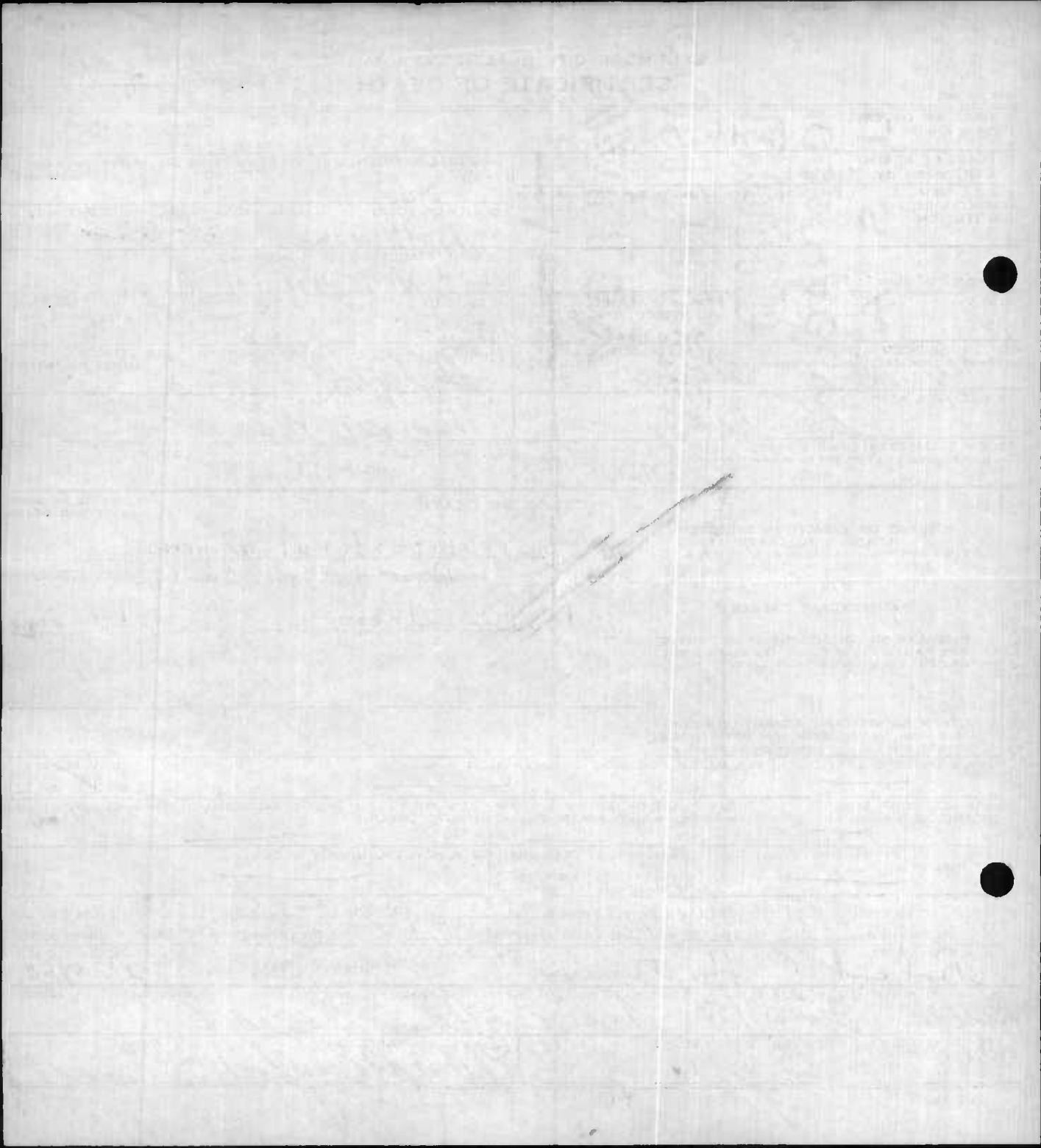
DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

FUNERAL DIRECTOR

Philip H. Hargis, 2024
William St



426
50 1714

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1714

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Josephine Walker

2. DATE
OF
DEATH

2/25/50

3. PLACE OF DEATH:
a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

624 N. Brice St.

c. CITY OR TOWN (If outside corporate limits, write R.I.R.L. and give township)
Baltimore 16-04

d. STREET ADDRESS (If rural, give location)

624 N. Brice St

5. SEX

F

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 24, 1896

9. AGE (In years: last birthday)

53

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Adam Tollmeyer

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

George L. Walker 624 N. Brice St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Occlusion

18 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerosis

2

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Severe malnutrition

3

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from June 15, 1949, to Feb. 25, 1950 that I last saw the deceased alive on Feb. 23, 1950, and that death occurred at 1:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE

William Langhain

23b. ADDRESS

4508 Edmondson Village

23c. DATE SIGNED

2/25/50

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

2-27-50

24c. NAME OF CEMETERY OR CREMATORY

National

24d. LOCATION (City, town, or county) (State)

Baltimore

MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Langhain

25. FUNERAL DIRECTOR

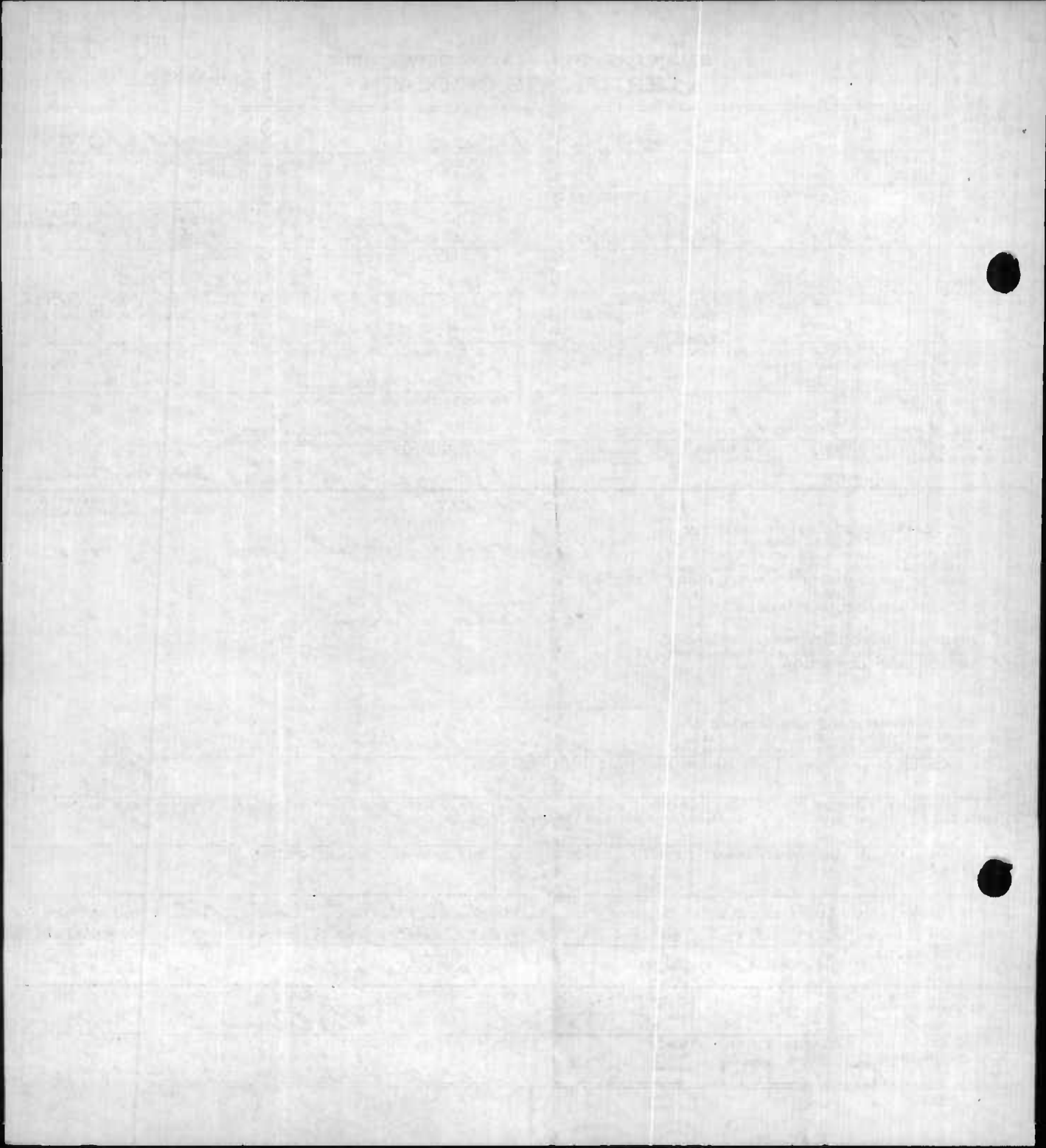
ADDRESS

George A. Farley Fulton & Fayette

VS 150

MEDICAL CERTIFICATION

VS 150 1714 794a



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1715
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1949 to Feb. 26, 1950, that I last saw the deceased alive on Feb. 26, 1950, and that death occurred at 6:45 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

VS 150

30430

94a

CERTIFICATE OF DEATH

1900

1. Name of deceased _____

2. Sex _____

3. Age _____

4. Date of death _____

5. Place of death _____

6. Cause of death _____

7. Signature of physician _____

8. Signature of registrar _____

9. Signature of informant _____

10. Signature of witness _____

11. Signature of _____

12. Signature of _____

13. Signature of _____

14. Signature of _____

15. Signature of _____

16. Signature of _____

17. Signature of _____

18. Signature of _____

19. Signature of _____

20. Signature of _____

516

1716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1716

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Louis Schonberger

2. DATE
OF
DEATH

FEB 24 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Md B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 7-05D. STREET ADDRESS (If rural, give location)
832 N. Chapel St

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

m. Widowed

8. DATE OF BIRTH

April 16, 1889

9. AGE (In years
last birthday)

60

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Steelworker

10B. KIND OF BUSINESS OR
INDUSTRY

Bethlehem Steel

11. BIRTHPLACE (State or foreign country)

Hungary

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Joseph Schonberger

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.
213-07-7644

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

? Myocardial Infarction

3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

? Overwhelming Septicemia

3 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 24, 1950, to Feb. 24, 1950, that I last saw the
deceased alive on Feb. 24, 1950, and that death occurred at 11:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

G. Robert C. Hartmann

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

2/23/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

March 1, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd. Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FEB 27 1950

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.

ADDRESS

2601 35 E. Madison St.

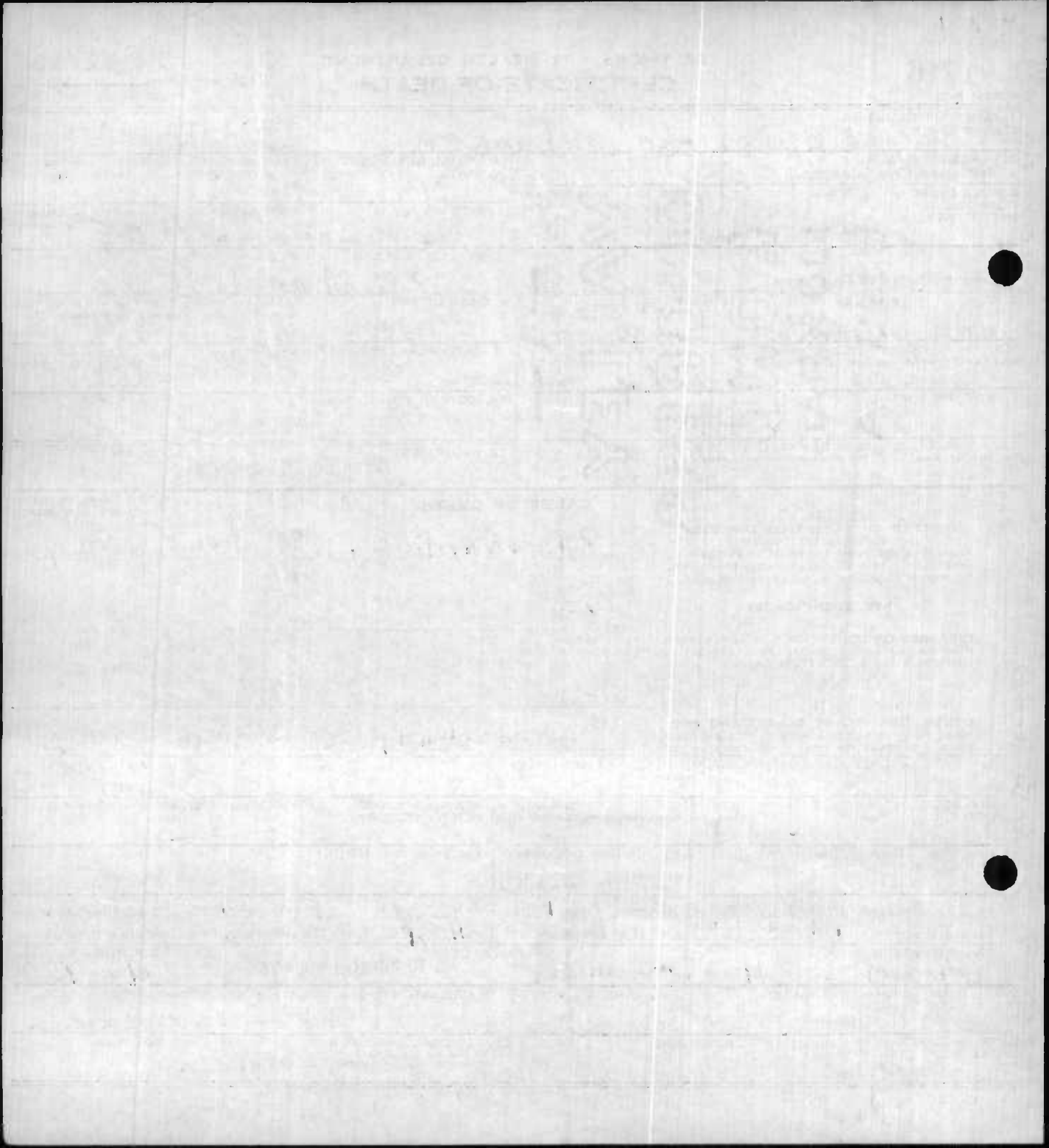
VS 150

49629

001719

94a

MEDICAL CERTIFICATION



400

1717

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1717

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM NEILL

2. DATE
OF
DEATH

2-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto. City

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

South Balto. Gen. Hospo.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto. City 24-04

D. STREET ADDRESS (If rural, give location)

1728 Byrd St.

Length of stay in Baltimore

Life

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years, last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

Male White

Single

May 16, 1874

75

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Watchman

10B. KIND OF BUSINESS OR INDUSTRY

Knot Twine Co.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Neill Sr.

14. MOTHER'S MAIDEN NAME

Mary Heikle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mary W. Hartlove 1728 Byrd St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Portal cirrhosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2-21-1950 to 2-24-1950, that I last saw the deceased alive on 2-24-1950, and that death occurred at 10:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

2-28-1950

Western

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

William Williams

Flynn & Fleming 1426 Light St.

VS 150

60204

12412

MEDICAL CERTIFICATION

CLERK OF THE DISTRICT COURT

1914-15

1914-15

1914-15

1914-15

1914-15

1914-15

1914-15

1914-15

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1718**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mr. Eugene Walden

2. DATE
OF

DEATH **Feb. 26, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

St. Joseph's Hospital

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

28-01

D. STREET ADDRESS (If rural, give location)

4112 Newton Avenue

C. Length of stay in Baltimore

33yr.

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Male

White

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Operator

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore Transit Co.

8. DATE OF BIRTH

5-17-1892

9. AGE (In years last birthday)

57

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Co. Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Edgar Walden

14. MOTHER'S MAIDEN NAME

Mary Louise Trickell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. J. Ardella Walden - 4112 Newton

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Adenocarcinoma of prostate**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **metastasis to bone**

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **1-26**, 19**50**, to **2-26**, 19**50**, that I last saw the deceased alive on **2-26**, 19**50**, and that death occurred at **3:10 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

Leonard J. Luck - 5305 Harford Rd

VS 150

45649

512

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH
DEPARTMENT OF HEALTH
DEPARTMENT OF HEALTH



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH443 50 1719
Registered No.320
50 1719
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mota Mutch</i>		2. DATE OF DEATH <i>2/25/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Frederick</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 9-06</i>	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2721 Fenwick Ave.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>March 3, 1885</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>	9. AGE (In years last birthday) <i>64</i>
11. BIRTHPLACE (State or foreign country) <i>Pa, LeBarron</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Klein felter</i>		14. MOTHER'S MAIDEN NAME <i>(?)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>John Mutch</i>		ADDRESS <i>2500 Strathmore Ave.</i>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Central Nervous</i> DUE TO <i>Hypertensive C. V disease</i> DUE TO <i>(?)</i> DUE TO <i>(?)</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>1</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m. from the causes and on the date stated above.			
23A. SIGNATURE <i>W. R. Armbrust</i>		23B. ADDRESS <i>4 Elm St. Wash</i>	
M. D.		23C. DATE SIGNED <i>2/26/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/1/50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>E. beneger Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Lebanon Pa.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 27 1950</i>		REGISTRAR'S SIGNATURE <i>William M. Williams</i>	
FUNERAL DIRECTOR <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Hayford Rd.</i>	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

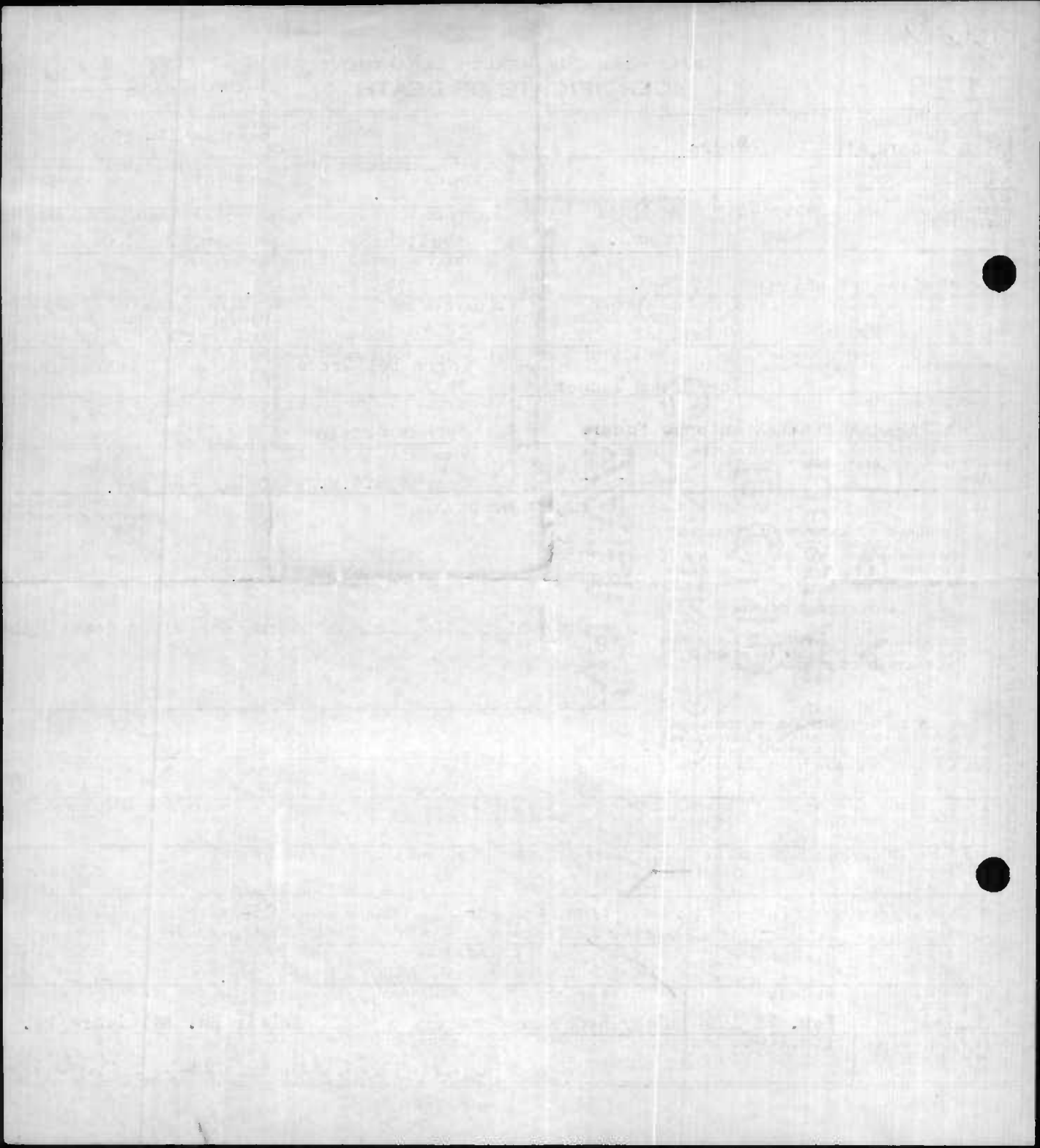
Registered No. **50 1720**

BIRTH NO. **1720**

1. NAME OF DECEASED (Type or Print) Pietro Nocera of Nocera, Pedro		2. DATE OF DEATH 2-25-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-02	
Length of stay in Baltimore 18 Yrs. Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1019 Granby ST.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 18 1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Ice Cream Vender	9. AGE (In years last birthday) Months Days 64 Yrs. 7 7
13. FATHER'S NAME XXXXXXXXXXXXXXXXXXXX Antonio Nocera		11. BIRTHPLACE (State or foreign country) Torre Del Greco Italy.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		12. CITIZEN OF WHAT COUNTRY Italy	
16. SOCIAL SECURITY NO. 218-14-2793		14. MOTHER'S MAIDEN NAME Sophia Brozia	
17. INFORMANT Records B.C.H. 4940 Eastern Ave.		ADDRESS	

MEDICAL CERTIFICATION	18. CAUSE OF DEATH, DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) Pneumonia DUE TO		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES (B) Bronchiectasis of right lower lobe & left lower lobe DUE TO		
	(C)		
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-24-1950 , to 2-25-1950 , that I last saw the deceased alive on 2-25-1950 and that death occurred at 9:35 AM from the causes and on the date stated above.					
23A. SIGNATURE P. H. Croger M.O.		23B. ADDRESS B.C.H. 4940 Eastern Ave.		23C. DATE SIGNED 2-25-1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Feb. 28 1950		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		24E. FUNERAL DIRECTOR Frank Della Noce		24F. ADDRESS 312 S. High St.	



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

500

50 1721

BIRTH NO. 1721

1. NAME OF DECEASED (Type or Print) BARBARA E. THIM			2. DATE OF DEATH FEB. 24, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE		
b. FULL NAME OF HOSPITAL OR INSTITUTION 3212 AVON AVE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE		
c. Length of stay in Baltimore LIFE			d. STREET ADDRESS (If rural, give location) 3212 AVON AVE		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH Dec. 23, 1889		9. AGE (in years last birthday) 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER			11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN B. THIM			14. MOTHER'S MAIDEN NAME MARY BERGLER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NO	17. INFORMANT ANTHONY THIM		
			ADDRESS 3212 AVON AVE		

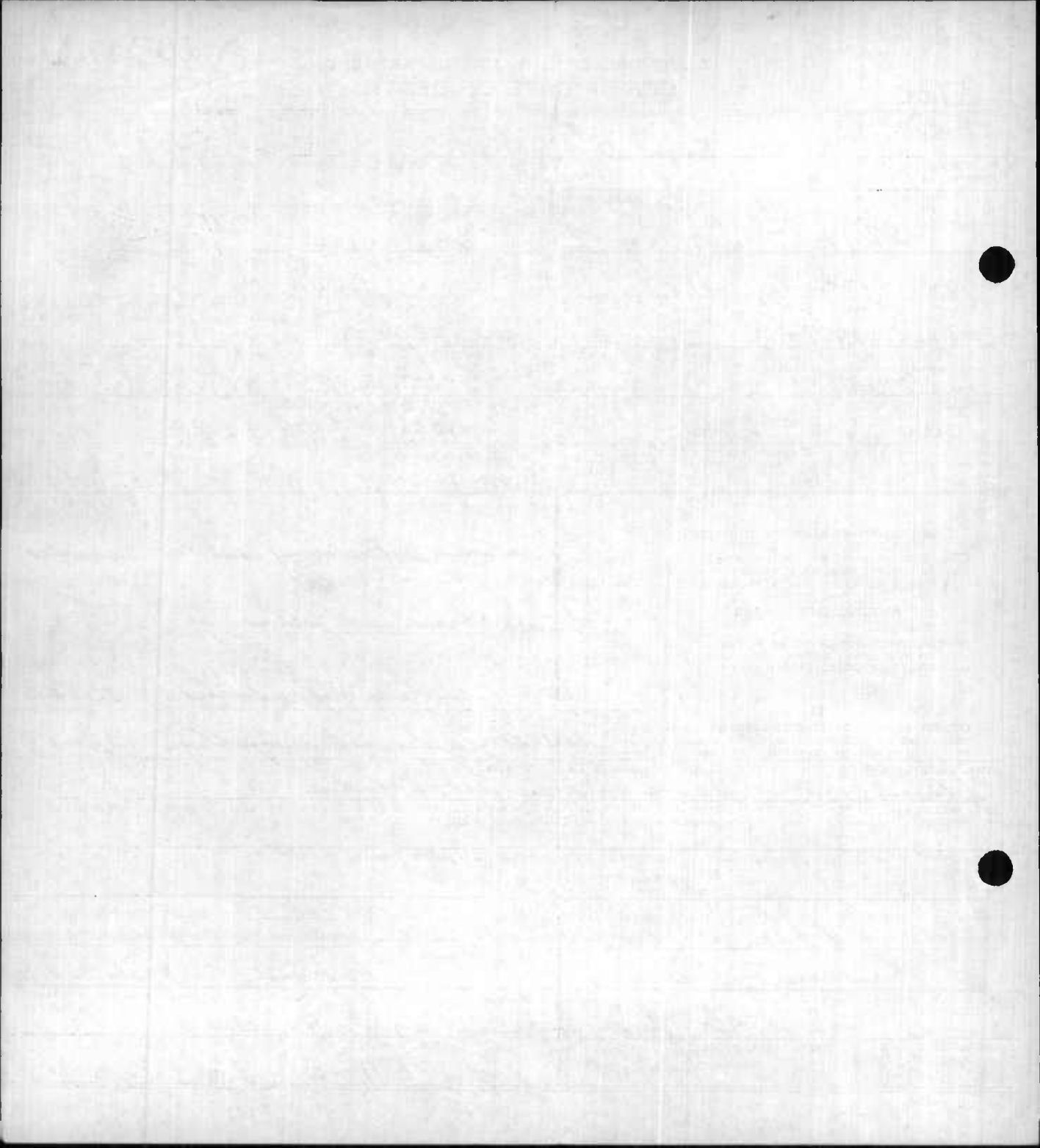
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Massive pulmonary embolus		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) Venous thrombosis following		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C) Acute gangrenous appendicitis Generalized lymphadenopathy		
19A. DATE OF OPERATION February 5, 1950		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION Acute gangrenous appendix		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb 5**, 1950, to **Feb 24**, 1950, that I last saw the deceased alive on **Feb 24**, 1950, and that death occurred at **2:50 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE **Frederick J. Vallmer** M.D. 23B. ADDRESS **6100 York Road** 23C. DATE SIGNED **Feb 26, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Feb 28, 1950	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. Balto. Md.	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950	REGISTRAR'S SIGNATURE Frederick J. Vallmer	25. FUNERAL DIRECTOR John A Moran	
		ADDRESS 3000 E. Balto St.	

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

420.0 50 1722
Registered No.

543
50 1722

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN A. UMLAUFF

2. DATE
OF
DEATH

Feb. 26th, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4128 Hamilton Avenue

4. USUAL RESIDENCE* (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4128 Hamilton Avenue

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

July 29, 1869

9. AGE (In years last birthday)

80

10 Under 1 Year Months Days 11 Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

paper hanger

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Umlauff

14. MOTHER'S MAIDEN NAME

Mary Ide

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.
none

17. INFORMANT

ADDRESS

Mrs. J. A. Umlauff, 4128 Hamilton Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Heart Disease

2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Generalized arteriosclerosis

many years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept- , 1949, to 2-26, 1950, that I last saw the deceased alive on 2-25, 1950, and that death occurred at 4:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Max R. English

M. D.

23B. ADDRESS

5713 Belair Rd. Balt 6, Md.

23C. DATE SIGNED

2-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

Mar. 1st, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

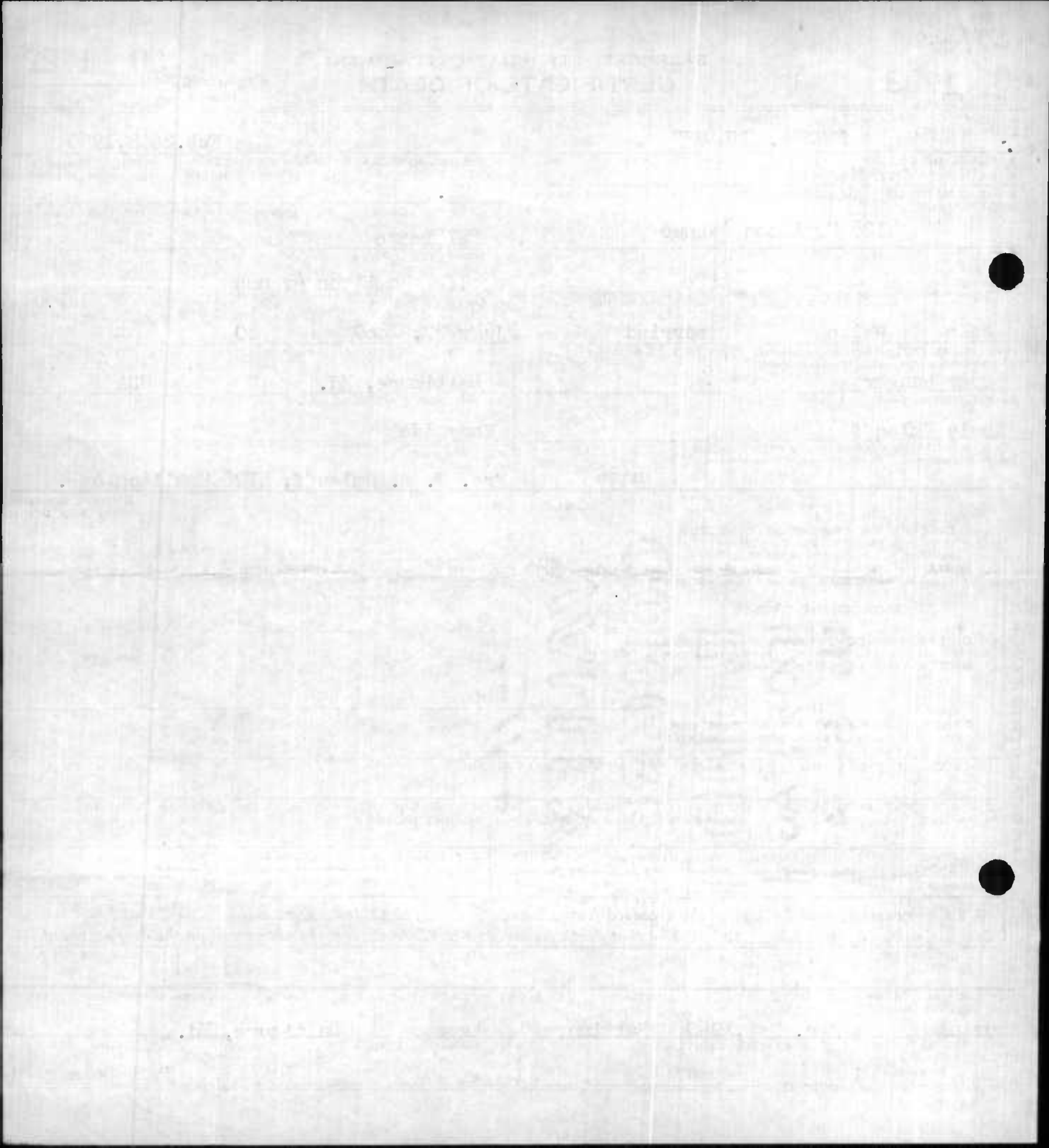
25. FUNERAL DIRECTOR

ADDRESS

Lazarus Funeral Home

7401 Belair Rd

FEB 27 1950



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1723

Registered No. _____

BIRTH NO. 50-03644

1. NAME OF DECEASED (Type or Print) Edward Lere Byrd		2. DATE OF DEATH February 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Prince Georges	
B. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mitchellville	
C. Length of stay in Baltimore 4 days		D. STREET ADDRESS (If rural, give location)	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH February 15, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 4 If Under 1 Year: Months: Days: Hours: Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Louis Byrd		14. MOTHER'S MAIDEN NAME Lilly Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		ADDRESS	

<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>(A) CONGENITAL MALFORMATION incompatible with life</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>(B) cor biloculare</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>INTERVAL BETWEEN ONSET AND DEATH 4 days</p>
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **February 15, 1950**, to **February 19, 1950** that I last saw the deceased alive on **February 19, 1950** and that death occurred at **12:25 P.m.**, from the causes and on the date stated above.

23A. SIGNATURE <i>William L. Hashman</i>	23B. ADDRESS 601 N. Broadway	23C. DATE SIGNED Feb. 20, 1950
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24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY <i>Hosp Disposal</i>	24D. LOCATION (City, town, or county) (State)
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DATE RECEIVED BY LOCAL REGISTRAR FEB 27 1950	REGISTRAR'S SIGNATURE <i>William L. Hashman</i>	25. FUNERAL DIRECTOR 1726	ADDRESS
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STATE OF NEW YORK
CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DECLARATION OF DEATH
I, the undersigned, being a duly qualified medical practitioner, do hereby certify that the above named person has died of the above named cause, and that the death has occurred at the above named place, on the above named date, and that the above named person was at the time of death of the age, sex, race, religion, education, occupation, and residence above stated.

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 19____.

Notary Public in and for the State of New York.

656

BALTIMORE CITY HEALTH DEPARTMENT

50 1724

CERTIFICATE OF DEATH

Registered No.

50 1724

1. NAME OF DECEASED (Type or Print) <i>Anna Rachel Warner</i>			2. DATE OF DEATH <i>Feb. 25, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>3214 W. Belvedere Ave</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>27-18</i>		
6. LENGTH OF STAY IN BALTIMORE <i>40 years</i>			D. STREET ADDRESS (If rural, give location) <i>3214 W. Belvedere Ave</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Apr. 8, 1892</i>	9. AGE (In years last birthday) <i>57</i>	10. UNDER 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <i>Reisterstown, Md</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>John Pohlman</i>			14. MOTHER'S MAIDEN NAME <i>L. Arnolda Youngling</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Mrs Earl Daly 3214 W. Belvedere</i>		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <i>Acute Pulmonary Congestion</i>		<i>1 day</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>Coronary thrombosis -</i>		<i>1 day</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>arteriosclerotic CVD & Hyp.</i>		<i>?</i>	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> ND <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>3-29</i> , 19 <i>49</i> , to <i>2-25</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>2-25</i> , 19 <i>50</i> , and that death occurred at <i>6 A</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Laurance H. Harnish M.D.</i>		23B. ADDRESS <i>3711 Fall Rd</i>		23C. DATE SIGNED <i>2-27-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Feb. 28/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Ashbury M.E. Church Reisterstown, Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 27 1950</i>		REGISTRAR'S SIGNATURE <i>William H. Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>Loring Byrne 5005 Ph. Heights Ave</i>	

3 Trans

650
1725BROWN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 1725

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Brown, Virginia</i>			2. DATE OF DEATH <i>2/26/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1514 Division St.</i>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Provident Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Annapolis</i>		
C. Length of stay in Baltimore <i>5</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>94 Fleet Street</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>3/18/1912</i>	9. AGE (In years last birthday) <i>37</i>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>			11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>-</i>			14. MOTHER'S MAIDEN NAME <i>-</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>-</i> ADDRESS		

18.	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Secondary Shock</i> DUE TO	<i>5 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>Intestinal Obstruction</i> DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>Strangulation of Ileum</i> <i>Postoperative Adhesions</i>	
19A. DATE OF OPERATION <i>2/25/50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Strangulation of ileum</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *2/21*, 19*50*, to *2/26*, 19*50* that I last saw the deceased alive on *2/26*, 19*50*, and that death occurred at *3:25* p. m., from the causes and on the date stated above.

23A. SIGNATURE <i>Dr. Thomas W. Moore Sr.</i> M. O.		23B. ADDRESS <i>Provident Hospital</i>	23C. DATE SIGNED <i>2/27/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <i>2/27/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Brown Hill</i>	24D. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 27 1950</i>	REGISTRAR'S SIGNATURE <i>Wm. B. Johnson</i>	25. FUNERAL DIRECTOR <i>Wm. B. Johnson</i> ADDRESS <i>Annapolis Md</i>	

1915

STATE OF NEW YORK

1/20/15

James J. ...

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...
...

...

2/12/15

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**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 1806 1726

BIRTH NO. 50 1726

1. NAME OF DECEASED
(Type or Print)

(Bandy)
Hugh Bandy Adams

2. DATE
OF
DEATH

2/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Henry Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE *MD*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Md 11-02

D. STREET ADDRESS (If rural, give location)

21 E. Eager St

Length of stay in Baltimore

Yrs.
Mos.
Days

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

July 16, 1889

9. AGE (In years last birthday)

60

If Under 1 Year Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

salesman

10B. KIND OF BUSINESS OR INDUSTRY

lumber

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Blake Adams

14. MOTHER'S MAIDEN NAME

Florence Bandy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

World War I

16. SOCIAL SECURITY NO.

245-22-2050

17. INFORMANT

ADDRESS

Mrs. Marian C. Adams 21 E. Eager St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebral Hemorrhage*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK

21F. HOW DID INJURY OCCUR?

I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

D. Lubinski

23B. CHIEF MEDICAL EXAMINER.....

23C. DATE SIGNED

23D. MEDICAL INVESTIGATOR.....

2/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Removal

24B. DATE

2/28/50

24C. NAME OF CEMETERY OR CREMATORY

Four Oaks

24D. LOCATION (City, town, or county)

Johnston Co., N. C.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Wm J. Dickson

ADDRESS

830 Balto. 17. Md.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Wm. L. Anderson
 Jan 12, 1912

512
50 1727BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1727
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

(VASEITY) VASHTI

THOMPSON

2. DATE
OF
DEATH

February 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

723 W. Saratoga Street

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

m

8. DATE OF BIRTH

7-4-78

9. AGE (In years
last birthday)

71

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Phillips

14. MOTHER'S MAIDEN NAME

Rachel Watts

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Emma T. Ester-Jewell-Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....23C. DATE SIGNED
2-27-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3-2-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

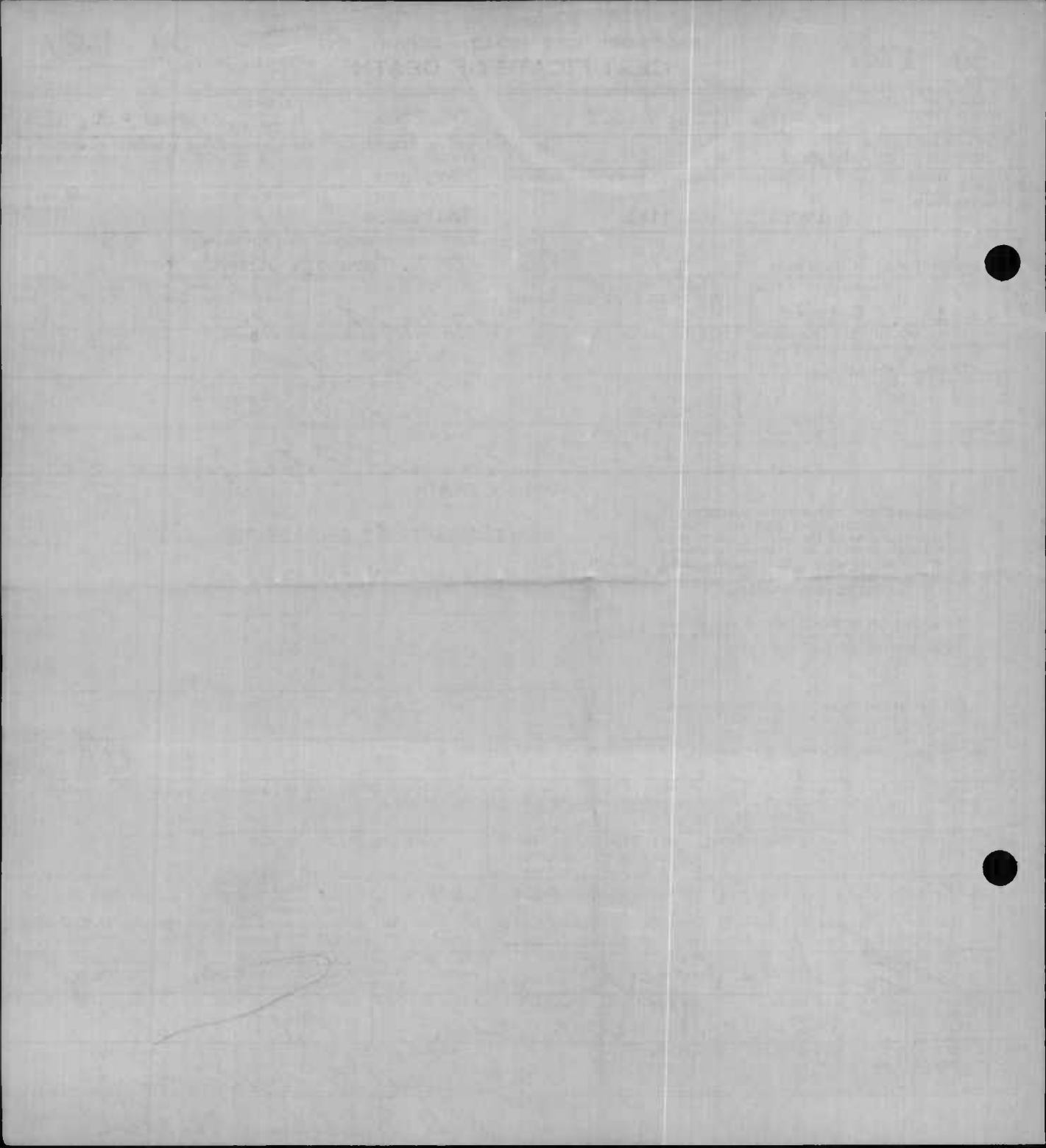
25. FUNERAL DIRECTOR

ADDRESS

FEB 27 1950

Samuel W. Sullivan Jr

1011 N. Ealington Ave 93D



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1728

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY Anne McCloskey		2. DATE OF DEATH 2/26/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 60 1913 Eutan Place		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 11-01	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) Mt. Royal Hotel	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 3/29/1863
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 86
11. BIRTHPLACE (State or foreign country) Portland Maine		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert McCloskey		14. MOTHER'S MAIDEN NAME Mary McAuley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Katherine R. Hoyer 2116 N. Chas. St		ADDRESS	

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Sensitivity Arteriosclerotic C-V. Disease**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Sensitivity**
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
2 yrs

MEDICAL CERTIFICATION

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct , 19 49 to Feb 26 , 19 50 , that I last saw the deceased alive on Feb 25 , 19 50 , and that death occurred at 2:30 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE E. Ellsworth Cook M.D.		23B. ADDRESS 2431 W. Ave		23C. DATE SIGNED 3/27/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/1/50		24C. NAME OF CEMETERY OR CREMATORY Cathedral	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25. FUNERAL DIRECTOR Wm. Cook Inc. 127 St. Paul St.		ADDRESS	

DATE RECEIVED BY
FEB 28 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

40 15 50
100 5 100
86 10 96

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Wyman Park Apts

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Retired Surgeon

Marine

13. FATHER'S NAME

Thomas Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Reginald Stewart 1550 Northwick Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary thrombosis

? min

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO
(C)

Arteriosclerotic heart disease

15 yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 25 Feb, 1950, to 25 Feb, 1950, that I last saw the deceased alive on 25 Feb, 1950, and that death occurred at 8:30 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

ntombment

2/28/50

Lorraine Mausoleum

Balt. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

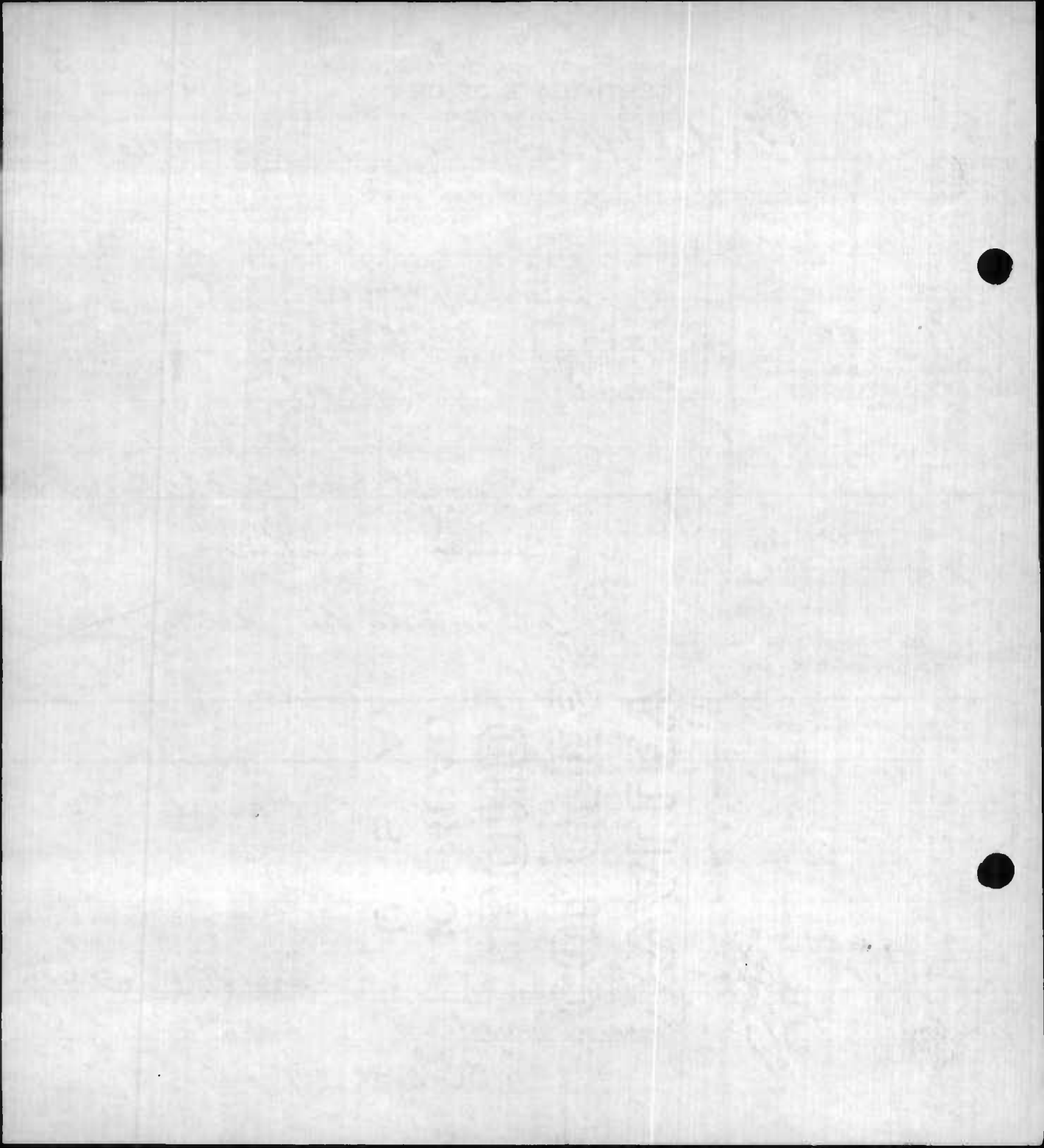
25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

Thurston Williams

Wm. C. Rogers, Inc. 1217 St. Paul St.



426
50 1730BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1730

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MILTON L. WALKER

2. DATE
OF
DEATH

Feb. 25, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1007 HARLEM AVE

c. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

1007 HARLEM AVE.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE Maryland

D. STREET ADDRESS (If rural, give location)

1007 HARLEM AVE-16-01

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MALE COLORED

MARRIED

8. DATE OF BIRTH

9. AGE (In years,
last birthday)10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

JAN. 25, 1896

54

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Postal Clerk

10B. KIND OF BUSINESS OR
INDUSTRY

U.S.P.O.

13. FATHER'S NAME

BARTLEY J. WALKER

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Md.

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

ANNA MAPP

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. RUTH WALKER -1007 HARLEM

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2, 1950, to 2-25, 1950, that I last saw the
deceased alive on 2-25, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Feb. 28, 1950

Arbutus Mem. Pk.

Arbutus, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

William

EARL Gilmore - 519 Mosher St.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Occupation		8. Cause of Death		9. Manner of Death		10. Signature of Registrar	
11. Signature of Medical Officer		12. Signature of Coroner		13. Signature of Police Officer		14. Signature of Priest		15. Signature of Minister	
16. Signature of Burial Officer		17. Signature of Undertaker		18. Signature of Cemetery Officer		19. Signature of Registrar		20. Signature of Registrar	
21. Signature of Registrar		22. Signature of Registrar		23. Signature of Registrar		24. Signature of Registrar		25. Signature of Registrar	
26. Signature of Registrar		27. Signature of Registrar		28. Signature of Registrar		29. Signature of Registrar		30. Signature of Registrar	
31. Signature of Registrar		32. Signature of Registrar		33. Signature of Registrar		34. Signature of Registrar		35. Signature of Registrar	
36. Signature of Registrar		37. Signature of Registrar		38. Signature of Registrar		39. Signature of Registrar		40. Signature of Registrar	
41. Signature of Registrar		42. Signature of Registrar		43. Signature of Registrar		44. Signature of Registrar		45. Signature of Registrar	
46. Signature of Registrar		47. Signature of Registrar		48. Signature of Registrar		49. Signature of Registrar		50. Signature of Registrar	
51. Signature of Registrar		52. Signature of Registrar		53. Signature of Registrar		54. Signature of Registrar		55. Signature of Registrar	
56. Signature of Registrar		57. Signature of Registrar		58. Signature of Registrar		59. Signature of Registrar		60. Signature of Registrar	
61. Signature of Registrar		62. Signature of Registrar		63. Signature of Registrar		64. Signature of Registrar		65. Signature of Registrar	
66. Signature of Registrar		67. Signature of Registrar		68. Signature of Registrar		69. Signature of Registrar		70. Signature of Registrar	
71. Signature of Registrar		72. Signature of Registrar		73. Signature of Registrar		74. Signature of Registrar		75. Signature of Registrar	
76. Signature of Registrar		77. Signature of Registrar		78. Signature of Registrar		79. Signature of Registrar		80. Signature of Registrar	
81. Signature of Registrar		82. Signature of Registrar		83. Signature of Registrar		84. Signature of Registrar		85. Signature of Registrar	
86. Signature of Registrar		87. Signature of Registrar		88. Signature of Registrar		89. Signature of Registrar		90. Signature of Registrar	
91. Signature of Registrar		92. Signature of Registrar		93. Signature of Registrar		94. Signature of Registrar		95. Signature of Registrar	
96. Signature of Registrar		97. Signature of Registrar		98. Signature of Registrar		99. Signature of Registrar		100. Signature of Registrar	

240
MS-135479
50 1731BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 17°

Registered No.

50 1731

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Daisy Roszell

2. DATE
OF
DEATH

2-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

401 Denison St.

20-07

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)Yrs.
Mos.
Days

Female

White

Widowed

8. DATE OF BIRTH

Apr. 2, 1878

9. AGE (In years
last birthday)

71

10. Under 1 Year 11. Under 24 Hours
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

H. W.

HOME

13. FATHER'S NAME

William Roszell

14. MOTHER'S MAIDEN NAME

Loula Lipscomb

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT Baltimore City Hospitals
Records--4940 Eastern Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinomatosis Primary site, apparent-
ly breast.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) ...
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) ...

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 2-3-____, 19 50 to 2-25-____, 19 50 that I last saw the
deceased alive on 2-25-____, 19 50, and that death occurred at 2:00 PM from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

To Be Approved By Chief Medical Examiner

50

CERTIFICATION APPROVED BY
Dr. Chester Lubinski per

R. B. Fisher M.D.

CHIEF OR ASST. MEDICAL EXAMINER.

522
50 1732PUNCOCHAR
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1732
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRANK J. PUNCOCHAR Sr.

2. DATE
OF
DEATH

2/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

WTA Bette Gen Hosp

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)10A. USUAL OCCUPATION (Give kind of
work done during most of working life, or if retired)

Shipwright

10B. KIND OF BUSINESS OR
INDUSTRY

Ship Building

13. FATHER'S NAME

John Puncochar

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived, if institution; residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1626 Church St - Curtis

8. DATE OF BIRTH

Oct 4, 1880

9. AGE (In years
last birthday)

69

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Europe

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Marie

17. INFORMANT

ADDRESS

Mrs Marie Puncochar 1626 Church St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TOArteriosclerotic Cardiac
vascular disease

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/24, 1950, to 2/25, 1950, that I last saw the
deceased alive on 2/25, 1950, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

Washington Williams, M.D.

John F. Kennedy Inc

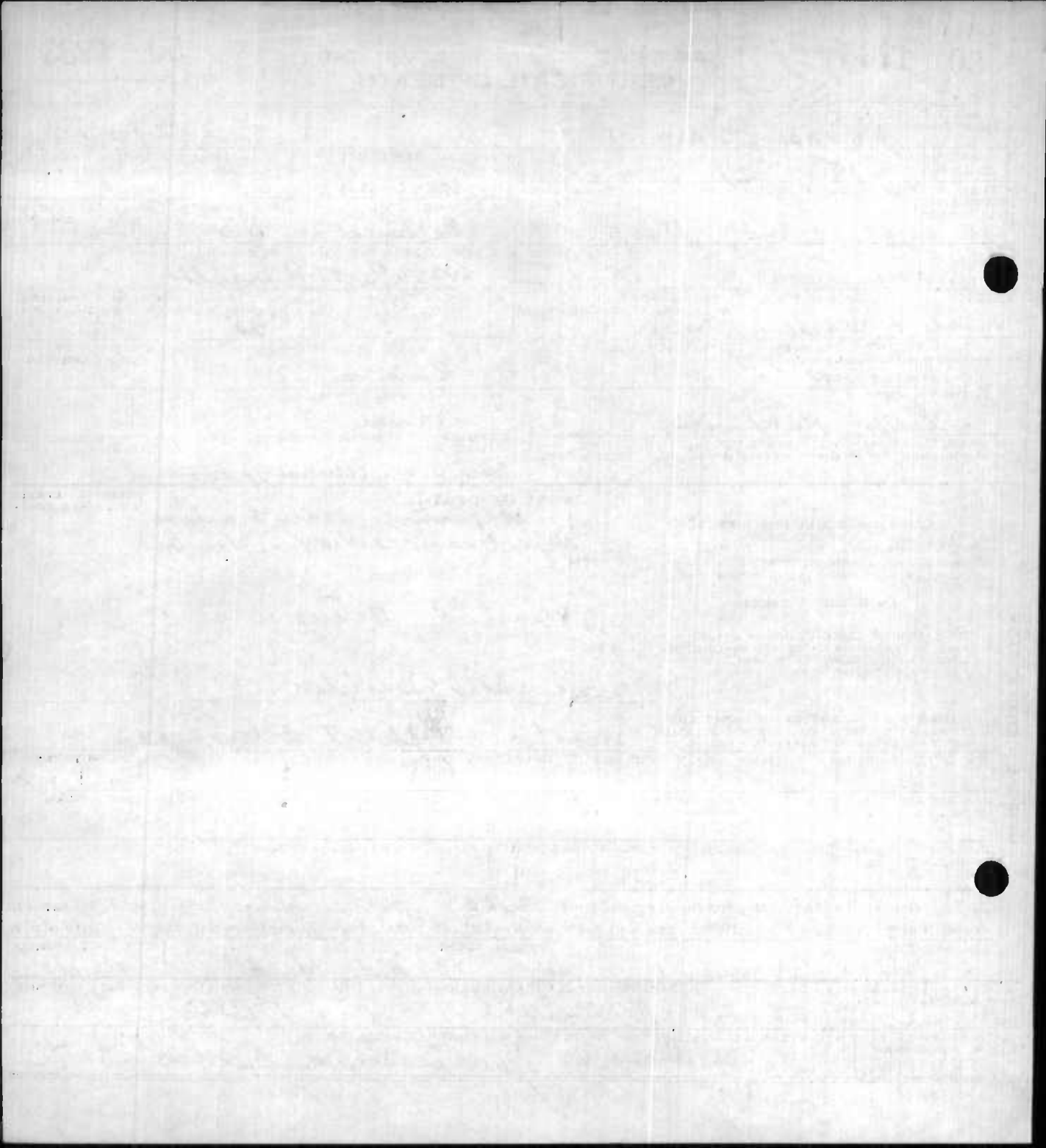
715 Light St

[illegible]

416
50 1733BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1733
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RACHAEL ALBERT		2. DATE OF DEATH 2-27-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION University of Md. Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-12	
D. STREET ADDRESS (If rural, give location) 3925 Park Heights		Yrs. 60 Mos. 65 Days	
5. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH ?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Louis Kaufman		14. MOTHER'S MAIDEN NAME Mina ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. A. M. Abramowitz		ADDRESS ?	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 1 Congestive Heart Failure 2 Hypertensive Cardiac Vascular Dis. 3 generalized arteriosclerosis 4 Diabetes Mellitus 5 Embolus to Popliteal Artery, right 2da.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/20 , 1950, to 2/27 , 1950 that I last saw the deceased alive on 2/27 , 1950, and that death occurred at 10¹⁰ AM. , from the causes and on the date stated above.			
23A. SIGNATURE Mark E. Walsh		23B. ADDRESS 219 Md. Hosp	
23C. DATE SIGNED 2/27/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-28-50	
24C. NAME OF CEMETERY OR CREMATORY Rosedale		24D. LOCATION (City, town, or county) (State) Balto Md	
DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1950		REGISTRAR'S SIGNATURE Thurston Williams	
25. FUNERAL DIRECTOR Jack Lewis		ADDRESS 2100 Eutan Rd	



253
50 1734ROSENTHAL
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH581.0 50 1734
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRIEDA ROSENTHAL		2. DATE OF DEATH 2-27-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION West Baltimore General Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balti. 18-01	
C. Length of stay in Baltimore 40 Yrs. Moer Days		D. STREET ADDRESS (If rural, give location) 924 West Fayette St	
5. SEX F	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 48
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel		14. MOTHER'S MAIDEN NAME Miriam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Michael Rosenthal		ADDRESS 924 W Fayette	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Biliary Cirrhosis (A) DUE TO	INTERVAL BETWEEN ONSET AND DEATH approx 5 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **2-20**, 19**50**, to **2-27**, 19**50** that I last saw the deceased alive on **2-27**, 19**50**, and that death occurred at **6:35 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE Joseph Shear M. D.	23B. ADDRESS West Ball Lane Hosp	23C. DATE SIGNED 2-27-50
--	---	---------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2-28-50	24C. NAME OF CEMETERY OR CREMATORY Rosedale	24D. LOCATION (City, town, or county) (State) Balti Md
DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1950		REGISTRAR'S SIGNATURE Thurston Williams, Jr.	
FUNERAL DIRECTOR Jack Lewis Inc		ADDRESS 2100 Eutan Rd	

STATE OF CALIFORNIA

DEPARTMENT OF THE TREASURY

OFFICE OF THE COMPTROLLER

STATE OF CALIFORNIA

DEPARTMENT OF THE TREASURY

OFFICE OF THE COMPTROLLER

STATE OF CALIFORNIA

DEPARTMENT OF THE TREASURY

OFFICE OF THE COMPTROLLER

STATE OF CALIFORNIA

DEPARTMENT OF THE TREASURY

OFFICE OF THE COMPTROLLER

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STATE OF CALIFORNIA

DEPARTMENT OF THE TREASURY

OFFICE OF THE COMPTROLLER

STATE OF CALIFORNIA

DEPARTMENT OF THE TREASURY

OFFICE OF THE COMPTROLLER

STATE OF CALIFORNIA

520
50 1735

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

491 50 1735
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) **PHENIS, Guy**

2. DATE OF DEATH **2-27-50**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **2828 St. Paul St**

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION **Dead on arrival to Union Memorial Hosp.**

6. CITY OR TOWN **Baltimore 12-06**

7. STREET ADDRESS (If rural, give location)
2828 St. Paul St. #18

8. DATE OF BIRTH **Dec. 17, 1949**

9. AGE (In years last birthday) **2**
10. Under 1 Year Months: **2**
11. Under 24 Hours Days: **10**
Hours: **10** Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Infant

10B. KIND OF BUSINESS OR INDUSTRY **None**

11. BIRTHPLACE (State or foreign country) **Fort Mead Md.**

12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Donald E. PHENIS**

14. MOTHER'S MAIDEN NAME **Virginia Brown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **No**

16. SOCIAL SECURITY NO.

17. INFORMANT **William F. Stengel, Md.**
ADDRESS **Union Mem. Hospital**

18. **491X**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **Broncho pneumonia**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY **R. F. Fisher**
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION **no**

19B. MAJOR FINDINGS OF OPERATION **no**

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) **no**

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **no**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **no**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **no**

21E. INJURY OCCURRED WHILE AT WORK ☐ HOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? **no**

22. I hereby certify that I attended the deceased from **Death on arrival**, 19___, to ___, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at ___ m., from the causes and on the date stated above.

23A. SIGNATURE **William F. Stengel, M.D.**
M. O. **Union Memorial Hosp.**

23B. ADDRESS

23C. DATE SIGNED **2-27-50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **2/28/50**

24C. NAME OF CEMETERY OR CREMATORY **New Cathedral**

24D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

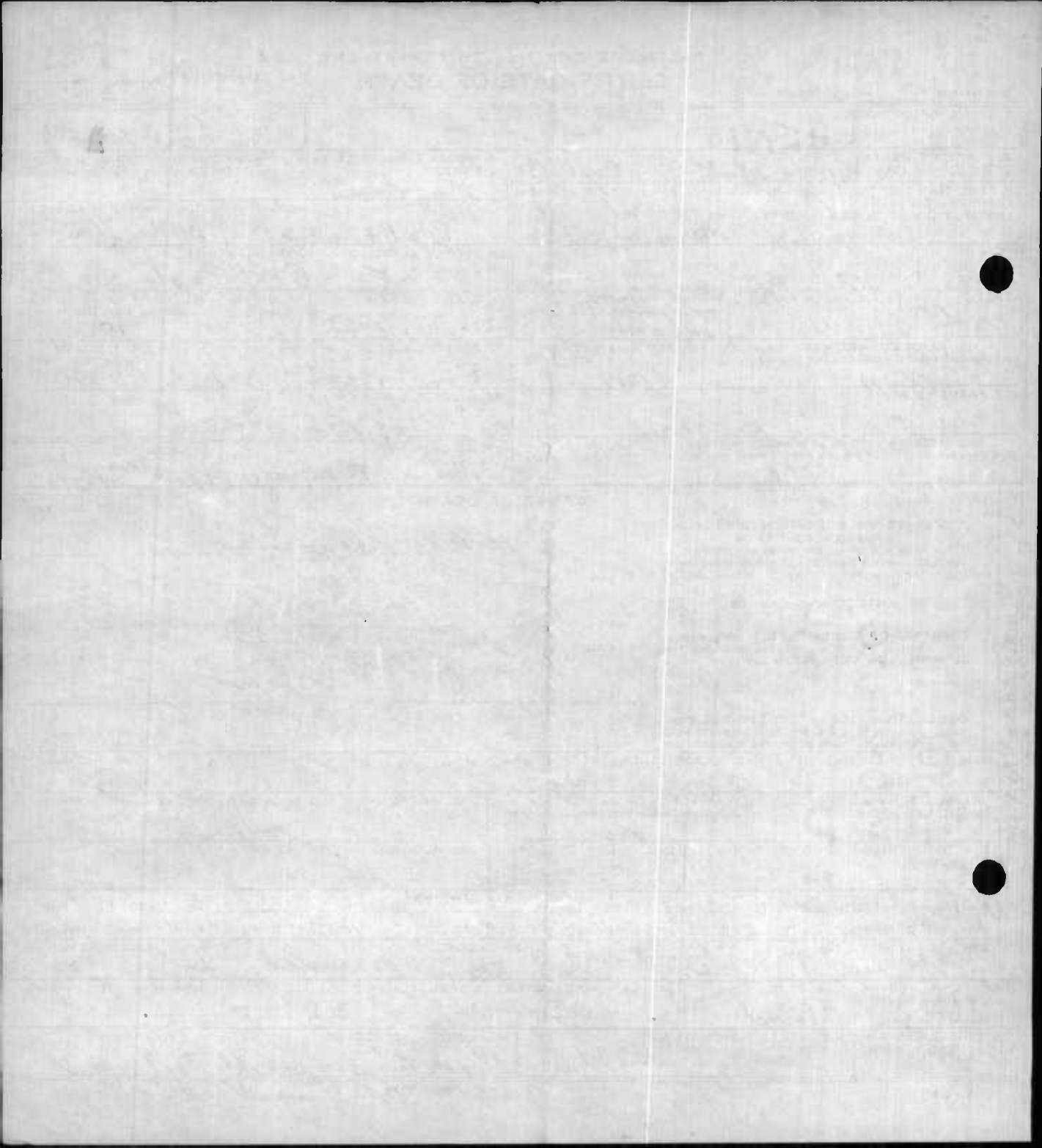
DATE RECEIVED BY LOCAL REGISTRAR **FEB 28 1950**

REGISTRAR'S SIGNATURE **William F. Stengel, M.D.**

25. FUNERAL DIRECTOR **Chas. J. Evans & Son, Inc.**
ADDRESS **118 N. Mt. Royal Ave.**

VS 150

107



50 1736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH44 ✓ 50 1736
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles W. Rogan

2. DATE
OF
DEATH

2/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

Cold Spring Nursing Home

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

19-02

D. STREET ADDRESS (If rural, give location)

19 N. Fulton Ave

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

4/2/1868

9. AGE (in years last birthday)

81

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Trane Director

10B. KIND OF BUSINESS OR INDUSTRY

B & O R R

11. BIRTHPLACE (State or foreign country)

Martinsburg W. Va.

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

Timothy Rogan

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Margaret L. Dickman

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cardio-VASCULAR RENAL DISEASE.

3-4 YRS

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-12, 1950, to 2-25, 1950, that I last saw the deceased alive on 2-24, 1950, and that death occurred at 1130 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Norman R. Kleiman

M. D.

23B. ADDRESS

3803 Edmondson Ave

23C. DATE SIGNED

2/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/1/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cn

24D. LOCATION (City, town, or county) (State)

4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR

FEB 28 1950

REGISTRAR'S SIGNATURE

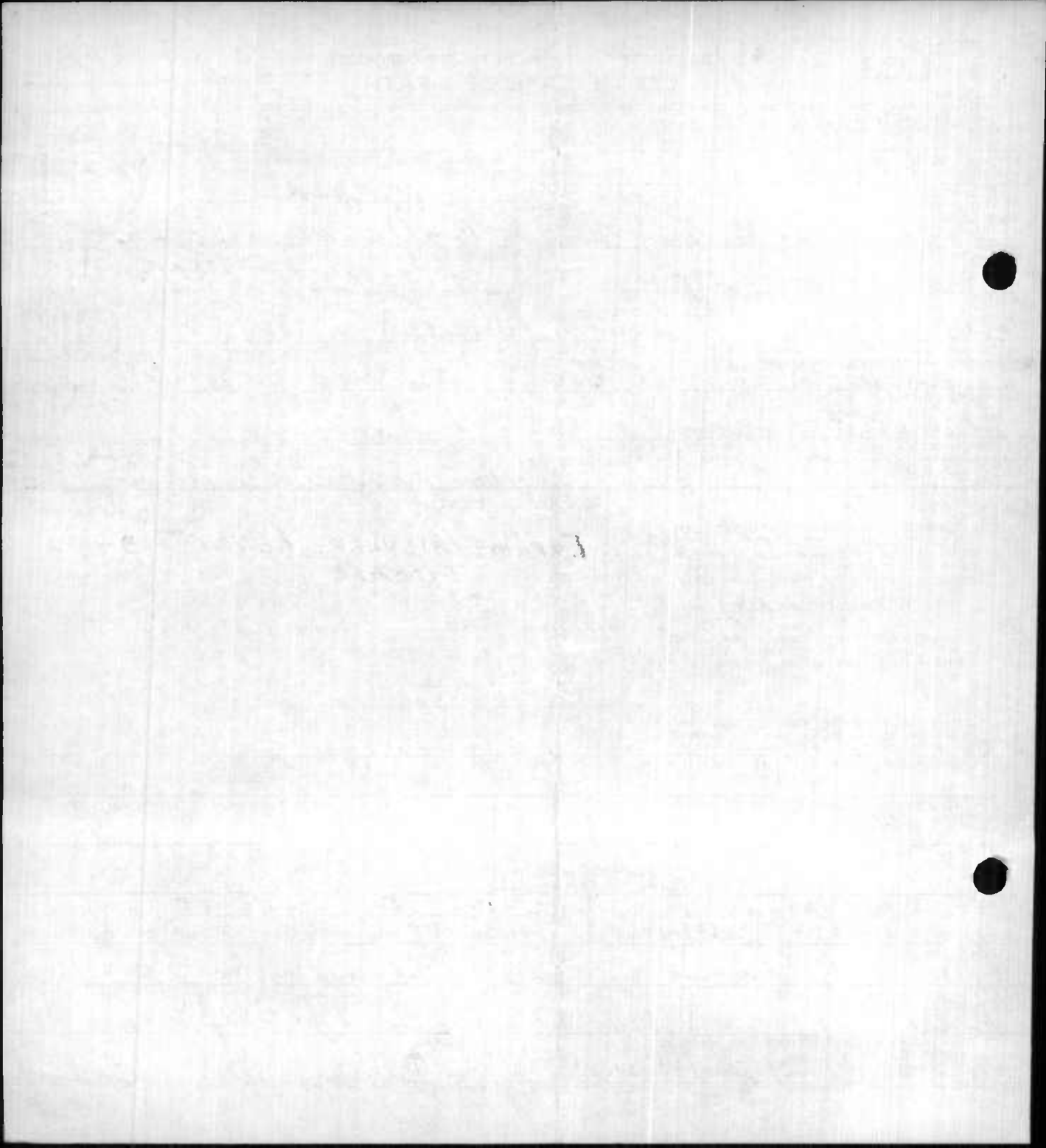
William H. Williams

25. FUNERAL DIRECTOR

John J. Egan & Son

ADDRESS

2 Hollins



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1737
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>Michalina Lena Kupidowski</u>			2. DATE OF DEATH <u>Feb. 26 /50</u>		
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland 620 S. Washington St.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION _____			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore 2-03</u>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <u>620 S. Washington St.</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>59</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <u>Unk.</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT ADDRESS <u>Adam Kupidowski 620 S. Washington</u>		

18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>(A) Chronic Myocarditis</u> DUE TO _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>(B) _____</u> DUE TO _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>(C) _____</u>	INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
--	---

19A. DATE OF OPERATION <u>none</u>		19B. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

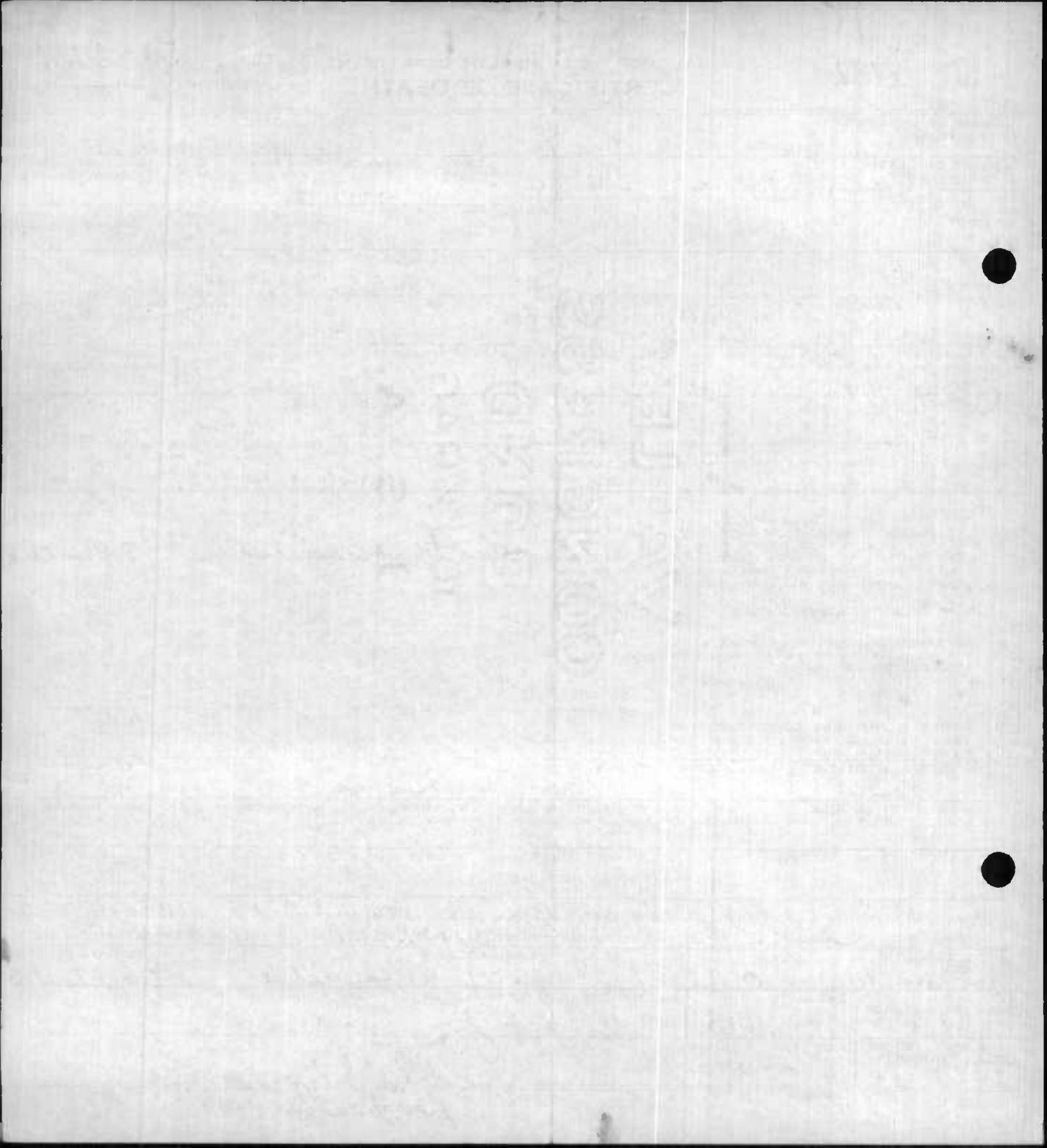
22. I hereby certify that I attended the deceased from Nov. 21, 1950, to Feb. 26, 1950, that I last saw the deceased alive on Feb. 26, 1950, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE Frank N. Oden M.D. 23B. ADDRESS 2701 N. Calvert St. 23C. DATE SIGNED Feb. 27, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE Mch. 2/50 24C. NAME OF CEMETERY OR CREMATORY Holy Rosary 24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1950 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR Fred W. Ozazowski ADDRESS 1930 Eastern Ave.

MEDICAL CERTIFICATION



50 1738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 434.3 50 1738

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Gerhart Smit / SMIT

2. DATE
OF
DEATH

Feb. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1913 Eutaw PLACE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

BALTIMORE 20-06

D. STREET ADDRESS (If rural, give location)

3150 LEEDS ST.

C. Length of stay in Baltimore

LIFE

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Yrs.
Mos.
Days

MALE

WHITE

8. DATE OF BIRTH

Jan. 4, 1875

9. AGE (in years
last birthday)

75

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR
INDUSTRY

SHIPYARD

13. FATHER'S NAME

Unknown

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NONE

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

MRS. Wm. Bonsal 2666 Frederick Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cardiac Weakness

2 mos -

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Senility

DUE TO

(C)

Blind

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Oct 1948 to Feb. 26, 1950, that I last saw the
deceased alive on 25 Feb 1950, and that death occurred at 1:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

Huntington Williams, M.D.

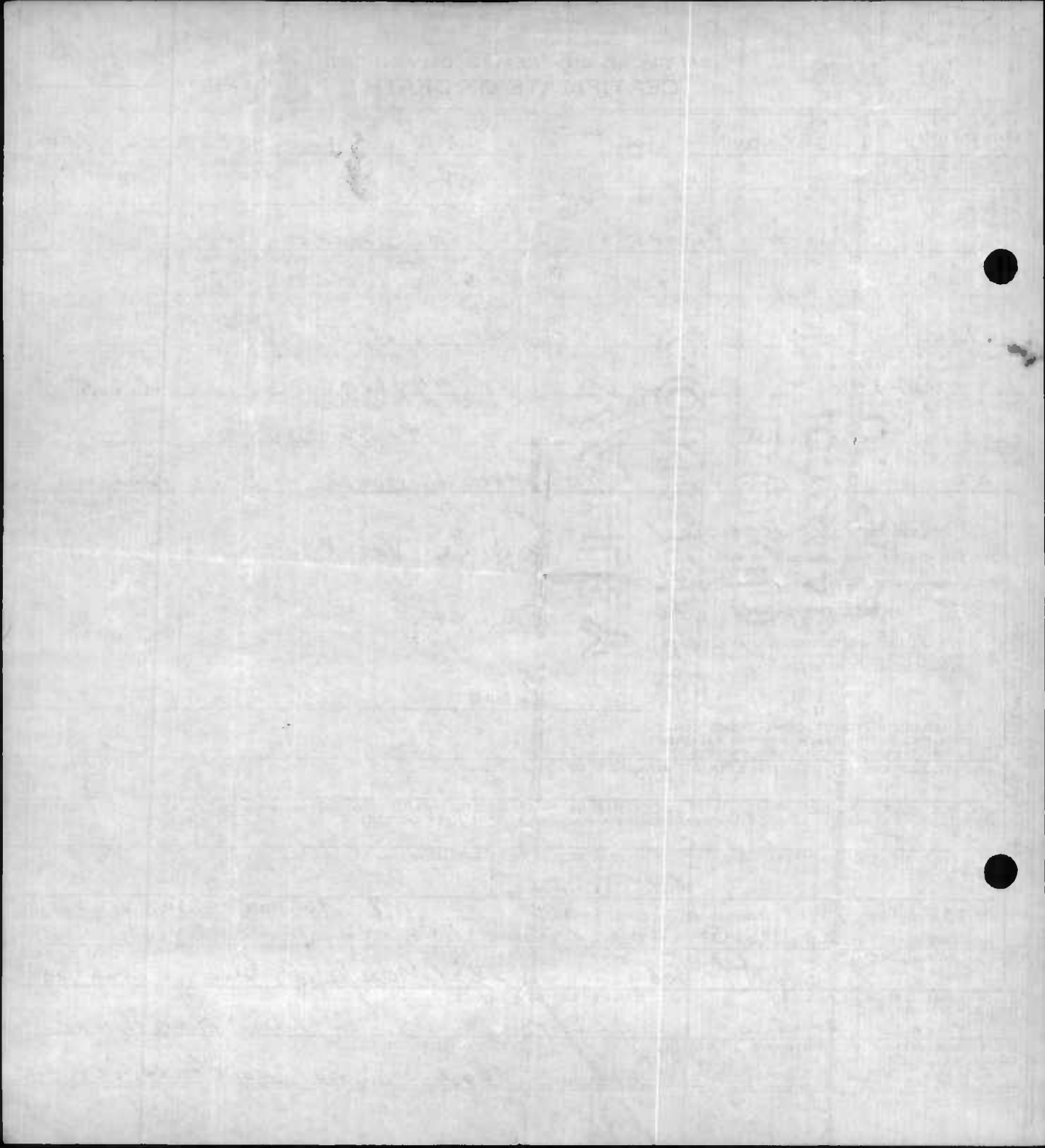
GEO. L. Schwab 2101 Frederick Ave.

VS 150

9884V

162B

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 1739

BIRTH NO. 261
263
1739

1. NAME OF DECEASED
(Type or Print)

MICHAEL

McGREEVY (McCREEDY) (ajm)

2. DATE
OF
DEATH

February 26, 1950

3. PLACE OF DEATH:

a. **Baltimore City, Maryland**

b. FULL NAME OF
HOSPITAL OR
INSTITUTION

Baltimore City Hospital

length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

MALE NURSE

10b. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Michael McGreevy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

World War II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. John McGreevy, Main St., Westernport, Md.

18. **E 936.9**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Subdural hematoma

DUPLICATE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE, (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUPLICATE

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)
Hospital

21c. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Baltimore City Hospital—4940 Eastern Ave

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY **Unknown—appar. sus-
pected 2-3 days fore death.**

21e. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21f. HOW DID INJURY OCCUR?

**Unknown—developed subdural hematoma
several days after admission to hospital**

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

W. J. McClafferty

23b. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23c. DATE SIGNED
2-27-50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24b. DATE

3/1/50

24c. NAME OF CEMETERY OR CREMATORY

Philox

24d. LOCATION (City, town, or county) (State)

Westernport Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Edw J Lickner + Son

ADDRESS

North Pa Ave

CERTIFICATE OF DEATH

NATIONAL CITY HEALTH DEPARTMENT

Philadelphia, Pa.

1900

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 1740

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES FRED MORGAN

2. DATE
OF
DEATH

Feb 26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

5317 Belair Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-02

D. STREET ADDRESS (If rural, give location)

5317 Belair Rd.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Building

11. BIRTHPLACE (State or foreign country)

Queen Ann Co., Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James F. Morgan

14. MOTHER'S MAIDEN NAME

Octavia Stark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

ADDRESS

Mrs. Catherine M. Morgan 5317 Belair Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

ONE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Sept 5, 1944 to Feb 26, 1950, that I last saw the deceased alive on Feb 24, 1950 and that death occurred at m from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3/2/50

Baltimore Cem.

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

Wm. J. Tickner & Sons

WM. J. TICKNER & SONS

Balto., Md.

195 V16V9 1743

1942

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

James B. Smith
of the County of Utah, State of Utah

Sept 25 1892
11:00 AM

630
50 1741BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH470.1 50 1741
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Adelaide Norwood

2. DATE
OF
DEATH

2/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Mt. St. Agnes College

C. Length of stay in Baltimore

21

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

Mt. St. Agnes College

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Singer & Teacher

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Not obtainable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

(Yes, no or unknown)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

June 26, 1868

9. AGE (in years last birthday)

81

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Not obtainable

17. INFORMANT

ADDRESS

Sister Mary Adelaide Mt. Wash.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ...

Coronary Thrombosis

6 Hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ...

Arteriosclerosis (General)

20 yrs

(C) ...

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1941 to Feb 27, 1950 that I last saw the deceased alive on Feb 27, 1950 and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/1/50

Mt. St. Agnes

Mt. Washington

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

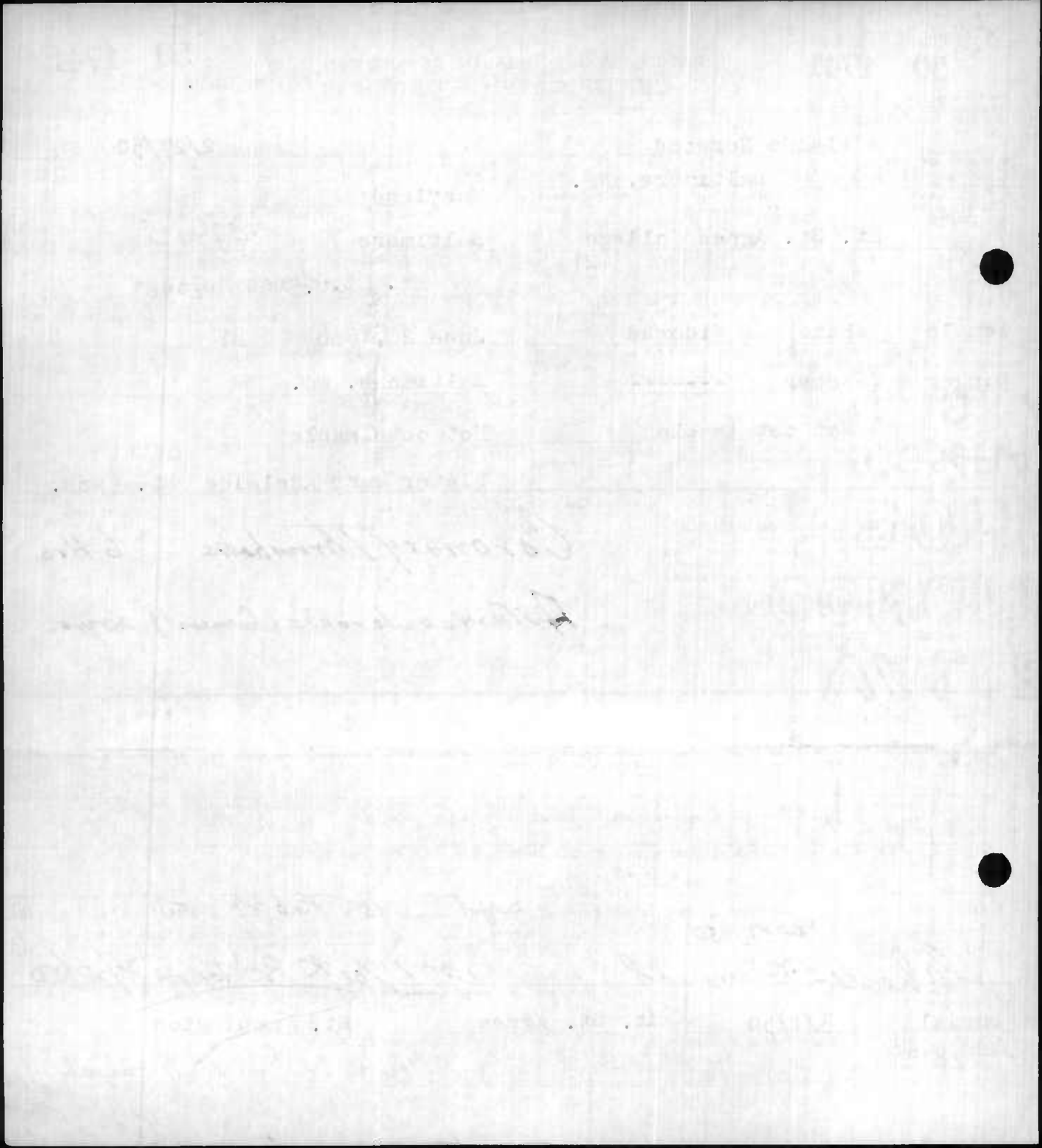
25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

W. H. Williams, M.D.

J. B. Medley, Jr. Son 805 N. Calver St.



00050 1742

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH1 50 1742
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ANNA

RAU

2. DATE
OF
DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore City Hospital

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-09

D. STREET ADDRESS (If rural, give location)

3503 Dillon Street

Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Jan. 16, 1889

9. AGE (In years
last birthday)

61

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

house wife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Sauter

14. MOTHER'S MAIDEN NAME

A. Rider

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Earl Rau 3503 Dillon St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
M.D. MEDICAL INVESTIGATOR ☒23C. DATE SIGNED
2-27-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn

24D. LOCATION (City, town, or county) (State)

7225 Eastern Ave.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Clarence F. Hoffmann

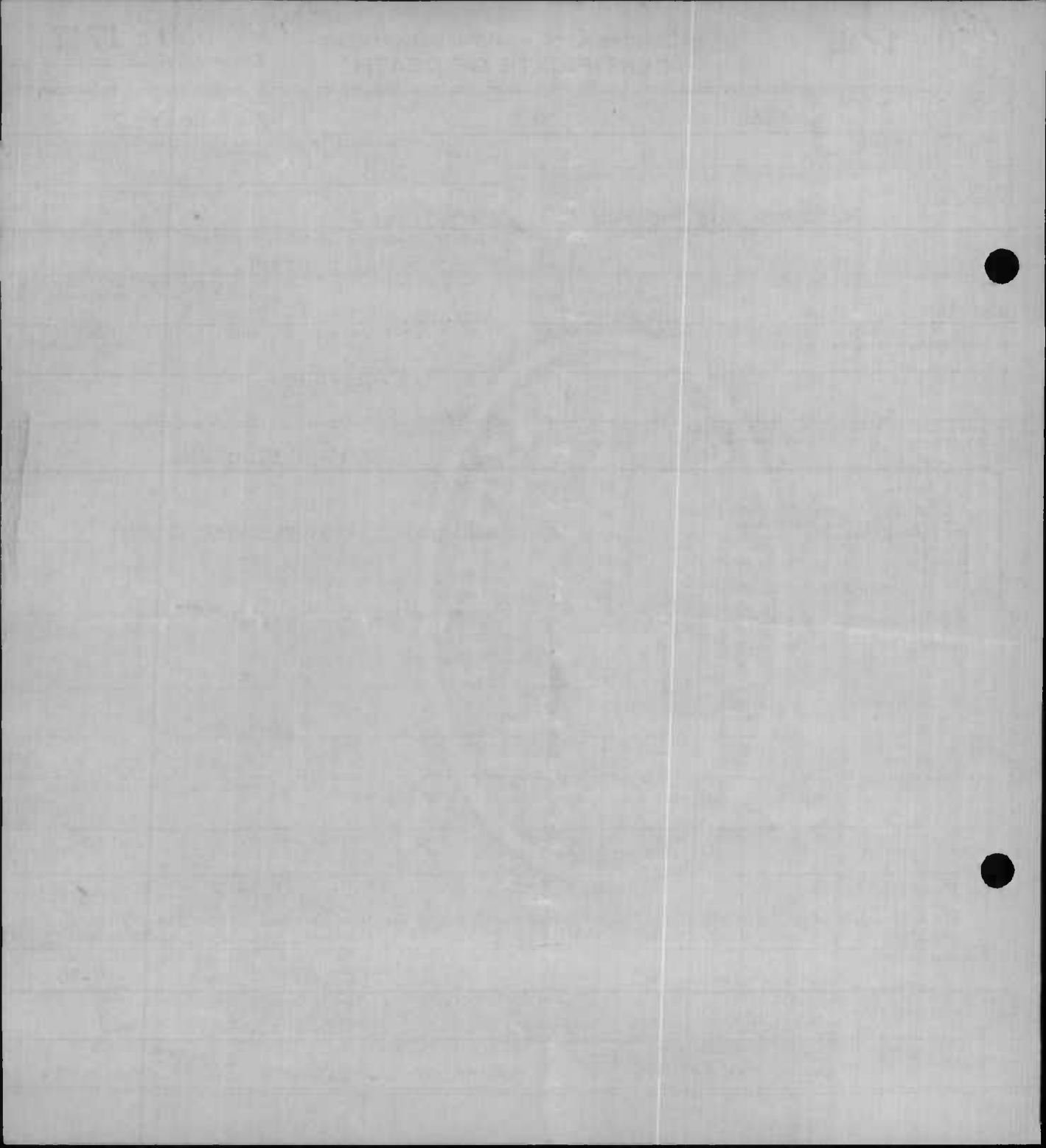
25. FUNERAL DIRECTOR

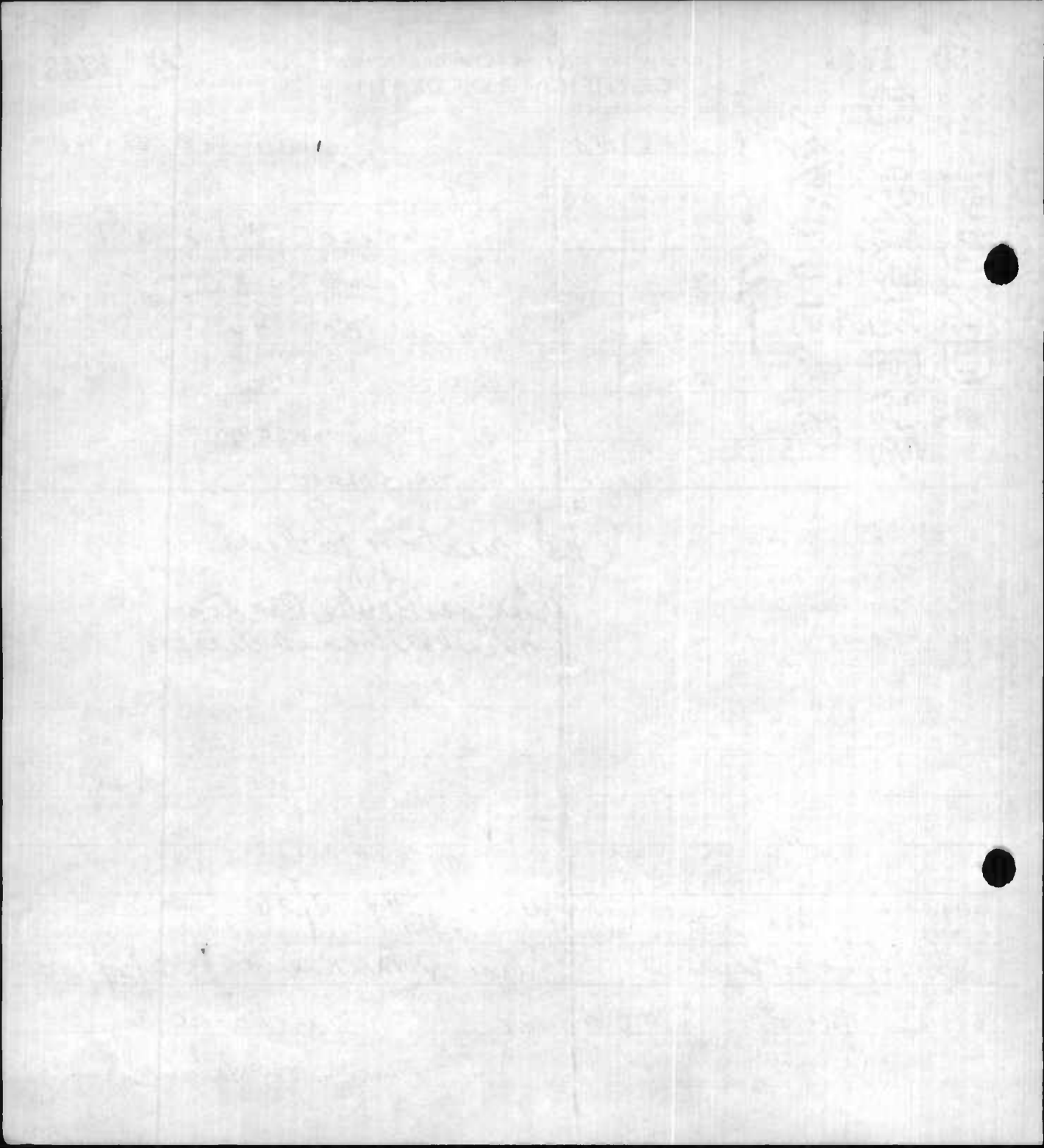
ADDRESS

Clarence F. Hoffmann 1639 Broadway.

9500001746

93D ✓





425

50 1744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 1744

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Robert Nelson

2. DATE
OF
DEATH

Feb 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 322 Morsley St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

322 Morsley St

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Annie Harper 322 Morsley St

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cor. Artery Insufficiency

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterial Hypertension

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb 22, 1950, to Feb 23, 1950, that I last saw the deceased alive on Feb 22, 1950, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

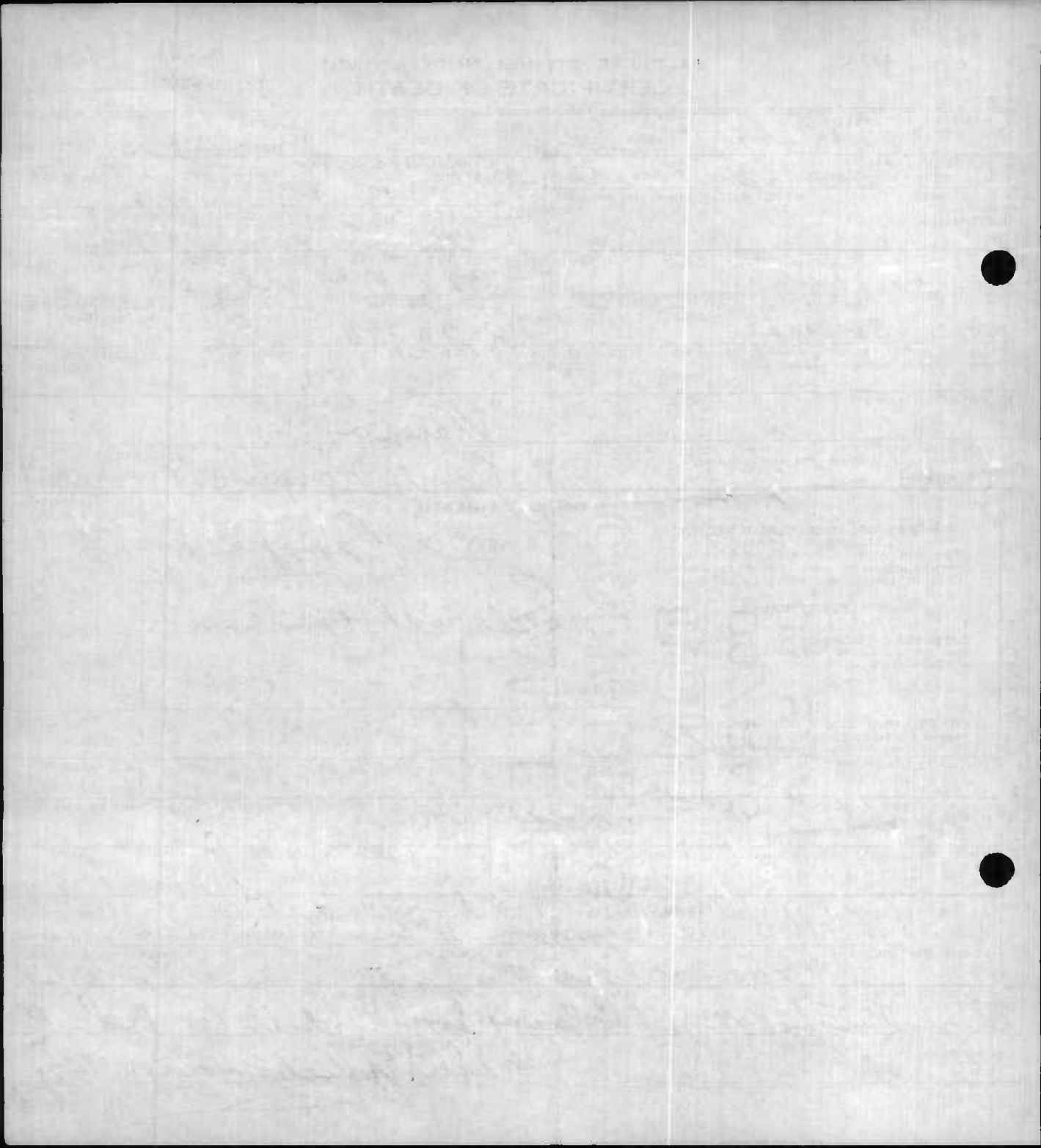
FEDERAL DIRECTOR

ADDRESS

FEB 28 1950

VS 150

92a



536
50 1745BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1745
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Eliza S. Henderson

2. DATE
OF
DEATH

Feb. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1154 N. Carey St.

Maryland

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

16-02

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1154 N. Carey St.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Aug. 15, 1874

9. AGE (In years

last birthday)

75

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William H. Cole

14. MOTHER'S MAIDEN NAME

Sophia Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

Mrs Blanch Bevans 1201 Springfield A

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHI
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

cerebral thrombosis

4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

arteriosclerotic cardio-vascular
disease

4+ yrs.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1950, to Feb. 26, 1950, that I last saw the
deceased alive on Feb. 26, 1950, and that death occurred at 6:00 p. m., from the causes and on the date stated above.

23A. SIGNATURE

James D. Carr

M. D.

23B. ADDRESS

1427 Madison Ave

23C. DATE SIGNED

2-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)
Burial

24B. DATE

3-1-50

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State)

Baltimore Co., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

(Mrs) Frances A. Hemsley

578 W. Biddle St.

Mar - 25 78

420
50 1746BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH443 50 1746
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Williams E. Mills

2. DATE
OF
DEATH Feb. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1821 Lauretta Ave.

C. Length of stay in Baltimore Life

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 20-01

D. STREET ADDRESS (If rural, give location)

1821 Lauretta Ave.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 18, 1880

9. AGE (In years
last birthday)

69

If Under 1 Year
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Butler

10B. KIND OF BUSINESS OR
INDUSTRY

Private Family

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Nathan Mills

14. MOTHER'S MAIDEN NAME

Julia Ann

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Mrs. Mary Mills 1821 Lauretta Av

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hypertensive Heart

2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-10-48, to 2-26-1950, that I last saw the
deceased alive on 2-25-1950, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3-1-50

Mt. Auburn Cem

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

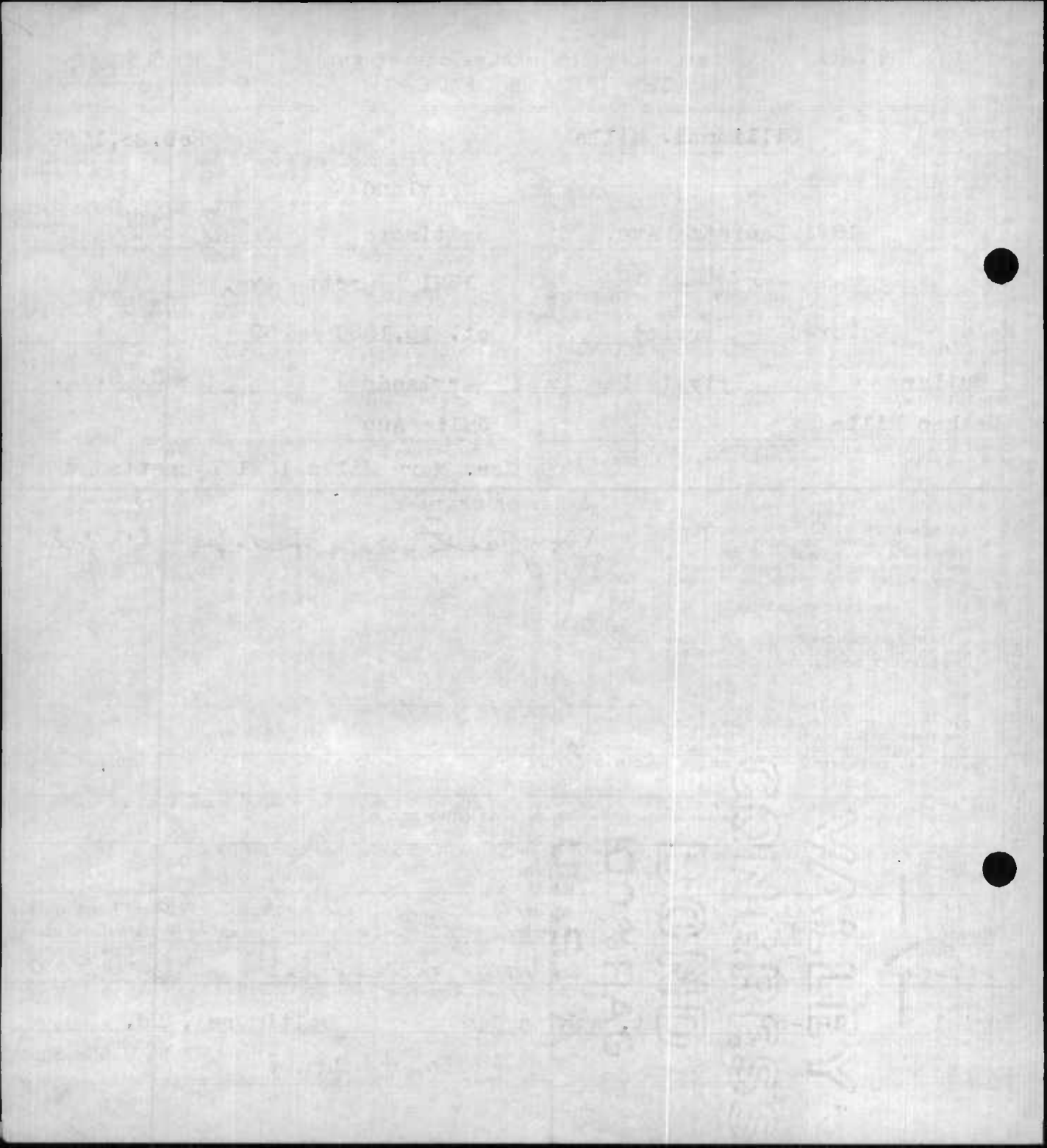
(Mrs) Frances A. Hemsley

578 W. Biddle St

VS 150

52086

931



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1747
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) **NORMAN C. MILES**

2. DATE OF DEATH **February 26, 1950**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION
Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)
510 E. Baltimore Street

5. SEX **male**
6. COLOR OR RACE **white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Divorced

8. DATE OF BIRTH
Feb. 7th, 1898

9. AGE (In years last birthday) **52**
If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook

10B. KIND OF BUSINESS OR INDUSTRY
Restaurant

11. BIRTHPLACE (State or foreign country)
Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **yes**
(If yes, give war or dates of service) **World War I**

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Chas. F. Miles - 8 Parke St. Ave. Aberdeen Md

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Crushed chest**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Corner of Pratt and Exeter Streets

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
February 26, 1950

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?
Pedestrian struck by auto

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED
Feb. 26, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)
Aberdeen, Harford Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR
FEB 28 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MEDICAL CERTIFICATION

STATE OF NEW YORK
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

263
1748BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1748

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE F. RICHARDSON

2. DATE OF DEATH
Feb. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

18-03

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

906 W. Pratt St.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Unknown 1869

9. AGE (In years last birthday)

80

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Watchman

10B. KIND OF BUSINESS OR INDUSTRY

Flannery Stable

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

James Flannery

ADDRESS

906 W. Pratt St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH.
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

Dr. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Feb. 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem.

24D. LOCATION (City, town, or county)

Ritchie Highway

(State)

DATE RECEIVED BY LOCAL REGISTRAR

FEB 28 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

John J. Lowan Son

ADDRESS

906 W. Pratt St.

Auguste E. Thialen
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

43 50 1749
Registered No.

450

BIRTH NO. 1749

1. NAME OF DECEASED (Type or Print) <i>Auguste E. Thialen</i>		2. DATE OF DEATH <i>Feb. 27, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1516 N. Patterson Park Ave.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <i>Baltimore 8-04</i>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>1516 N. Patterson Park Ave.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Sept. 24, 1872</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Germany</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>	
13. FATHER'S NAME <i>Adam Ludwig Gutherlet</i>		14. MOTHER'S MAIDEN NAME <i>Ernestine Schabtein</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS <i>Marie Bordes, 1533 N. Patterson Park Ave.</i>	

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *My pericardial heart disease*
DUE TO

INTERVAL BETWEEN ONSET AND DEATH
?

II
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

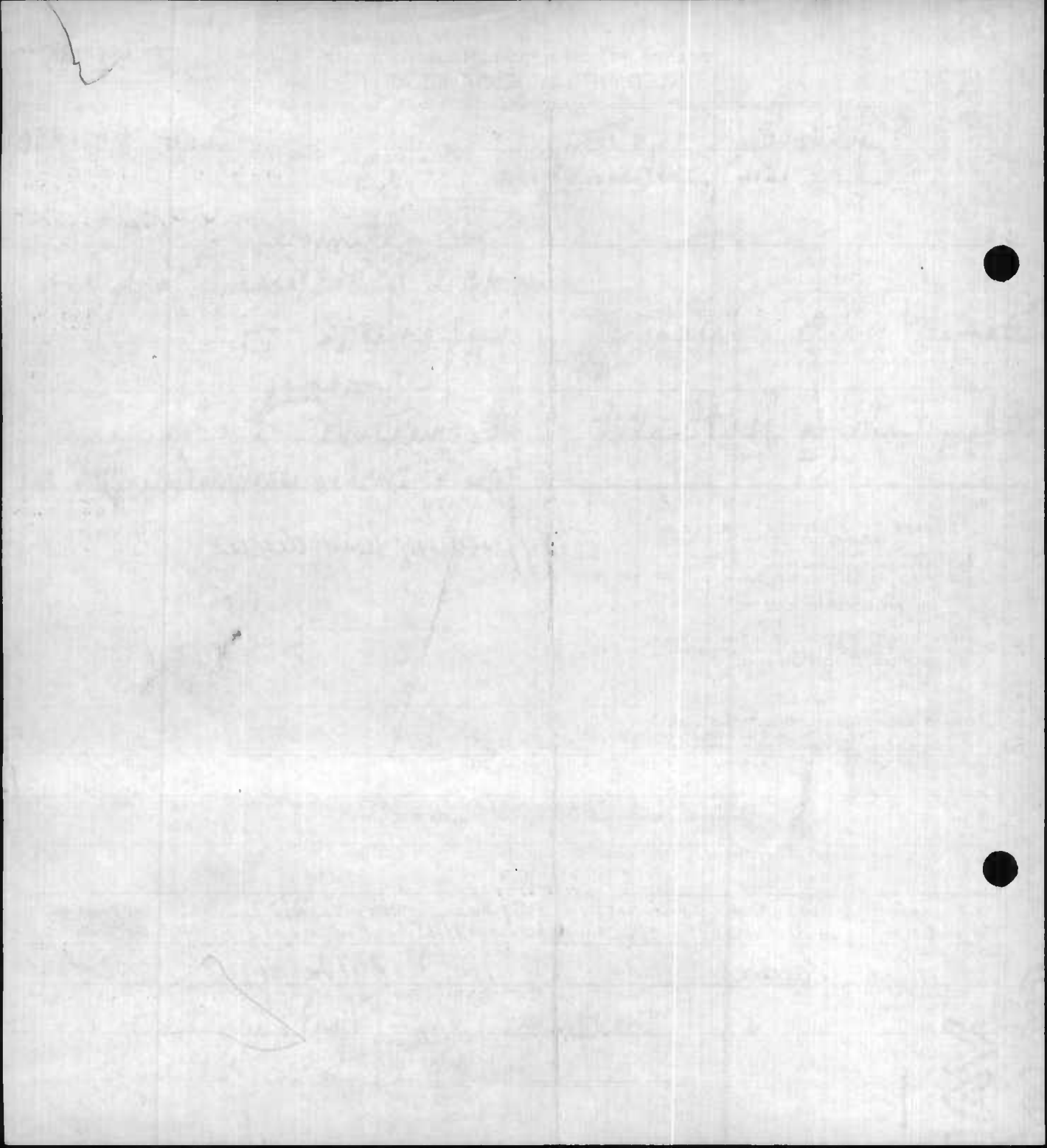
MEDICAL CERTIFICATION

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>8/26</i> , 19 <i>46</i> to <i>2/27</i> , 19 <i>50</i> that I last saw the deceased alive on <i>2/26</i> , 19 <i>50</i> , and that death occurred at <i>11:15 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Max Braun</i>		23B. ADDRESS <i>1501 N. Milton Ave.</i>		23C. DATE SIGNED <i>2/28/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>3-1-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>	
24D. LOCATION (City, town, or county) <i>North Ave. Balto. Md.</i>		24E. LOCATION (City, town, or county) <i>North Ave. Balto. Md.</i>		24F. LOCATION (City, town, or county) <i>North Ave. Balto. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>FEB 28 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. H. Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>John C. Miller, Inc. 2435 E. Olney St.</i>	

VS 150

19500001752

93D



452

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH5410 50 1750
Registered No.

BIRTH NO. 1750

1. NAME OF DECEASED (Type or Print) RICHARD HENRY WILLIAMS <i>Richard Williams</i>			2. DATE OF DEATH 2-27-50		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSP.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-02		
6. Length of stay in Baltimore Life			d. STREET ADDRESS (If rural, give location) 4719 Harford Rd.		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH October 14, 1890		9. AGE (In years last birthday) 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.CO.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Richard H. Williams			14. MOTHER'S MAIDEN NAME Ida E. Brian		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes		16. SOCIAL SECURITY NO. 705-09-3996	17. INFORMANT 4719 Harford Road Mrs. Katherine E. Williams		

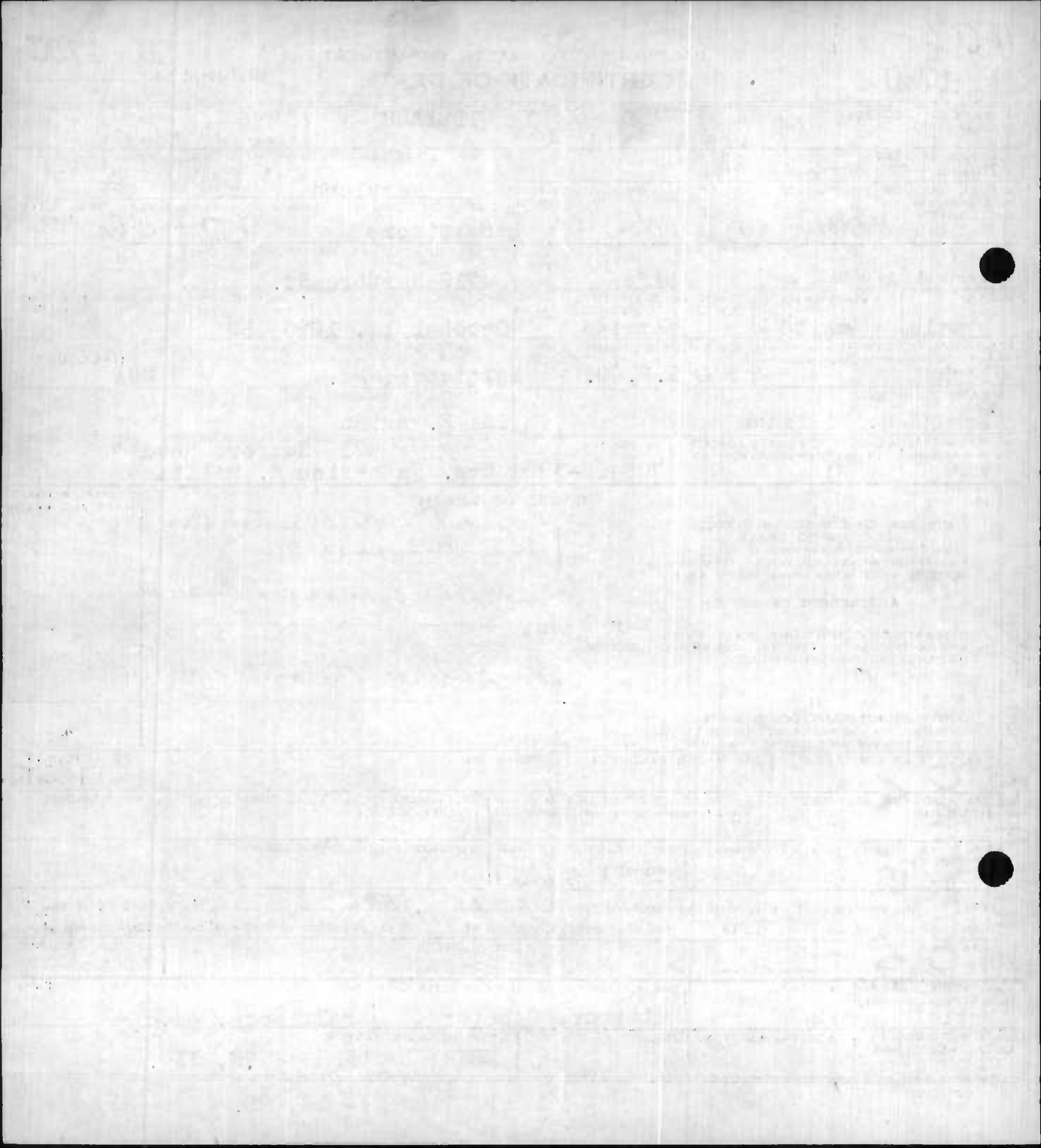
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Post-operative Gastric Resection for Duodenal Ulcer MULTIPLE Pulmonary Embolism from Left Femoral Phlebo-Thrombosis			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-15-1950 to 2-27-1950 , that I last saw the deceased alive on 2-27-1950 , and that death occurred at 9:45 A.m. , from the causes and on the date stated above.					
23a. SIGNATURE <i>H. G. Swocher</i>		23b. ADDRESS <i>Univ. Hosp.</i>		23c. DATE SIGNED 2-27-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3/2/50	24c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		24d. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1950		REGISTRAR'S SIGNATURE <i>Henry Sander</i>		25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.	

VS 150

26647 BALTIMORE - 13, MD.

1176

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1751
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY CAHILL BOULDEN

2. DATE
OF
DEATH Feb. 26, 19503. PLACE OF DEATH:
A. Baltimore City, MarylandB. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE 6028 Old Harford Rd.
Beech Hill Nursing Home

Length of stay in Baltimore Life

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 7-03D. STREET ADDRESS (If rural, give location)
922 N. Patterson Park Avenue5. SEX
F6. COLOR OR RACE
W7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Widow

8. DATE OF BIRTH

Aug. 21, 1871

9. AGE (In years
last birthday) 7810. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
Housewife10B. KIND OF BUSINESS OR
INDUSTRY
at home11. BIRTHPLACE (State or foreign country)
Maryland12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

? Cahill

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
no16. SOCIAL
SECURITY NO.
none17. INFORMANT 302 S.-4th. St. Darby, Pa.
Miss Lydia Grayson

18. CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE, (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan - 1942 to Feb. 26, 1950, that I last saw the deceased alive on Feb. 25, 1950, and that death occurred at 12:10 p.m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

burial

3/1/50

Druid Ridge Cemetery

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

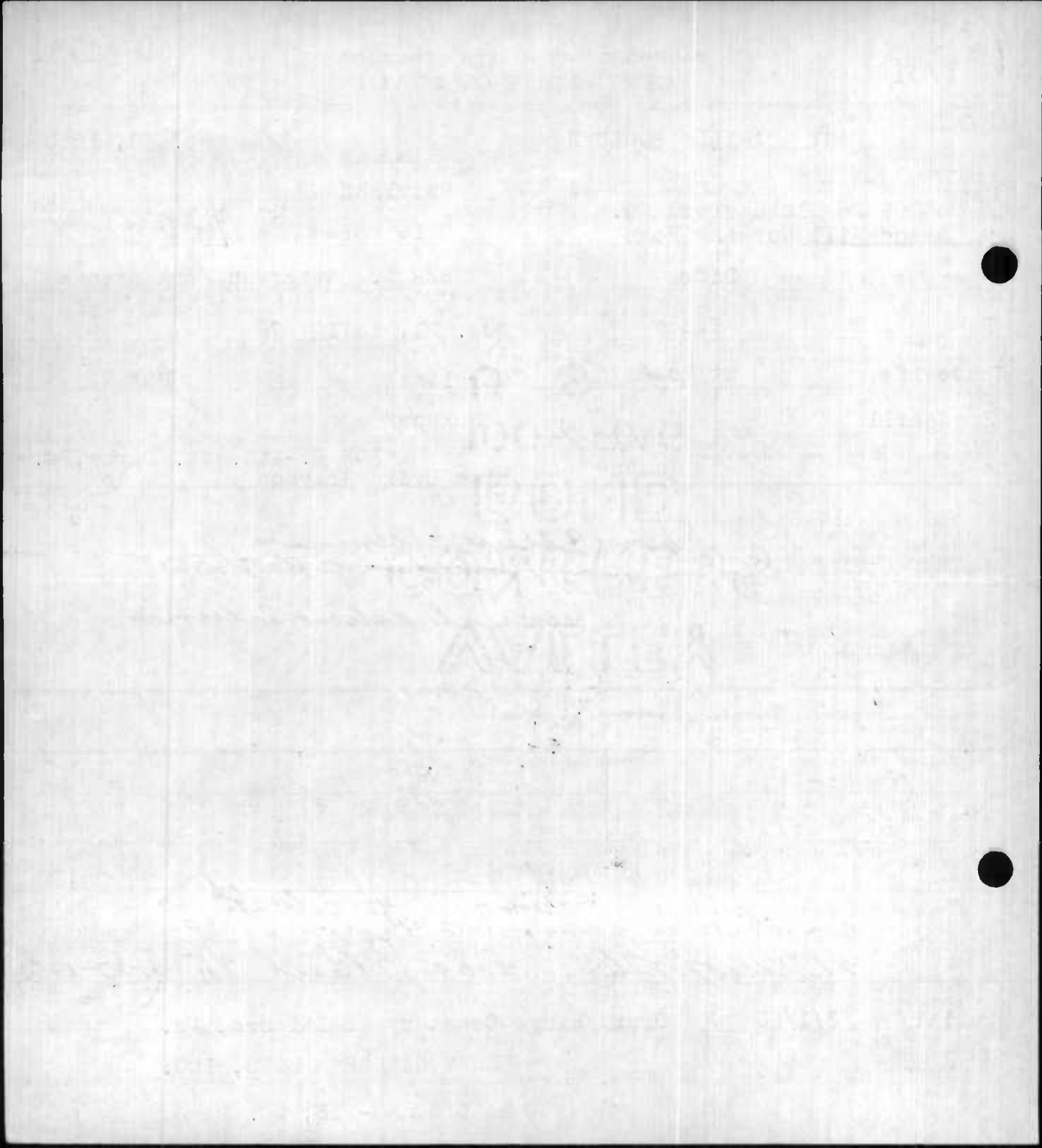
25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

HARRINGTON WILLIAMS

HENRY SANDER & SONS, INC.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

MARY BURNS

2. DATE
OF
DEATH

Feb. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY _____

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

24 S. Collington Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

24 S. Collington Avenue

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

June 16, 1890

9. AGE (In years last birthday)

59

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Adam Paff

14. MOTHER'S MAIDEN NAME

Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.
None

17. INFORMANT **24 S. Collington Ave.**
James E. Burns

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebral Apoplexy**
DUE TO **Cerebral arterio sclerosis**

acute

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Chf Endocarditis & Hypertension**
DUE TO **Chf Hypertension**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 18, 1948** to **Feb. 26, 1950**, that I last saw the deceased alive on **Feb. 26, 1950** and that death occurred at **6:00 p. m.**, from the causes and on the date stated above.

23A. SIGNATURE

James E. Burns

23B. ADDRESS

2007 E. Rutth

23C. DATE SIGNED

2/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Schwartz Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

FEB 28 1950

REGISTRAR'S SIGNATURE

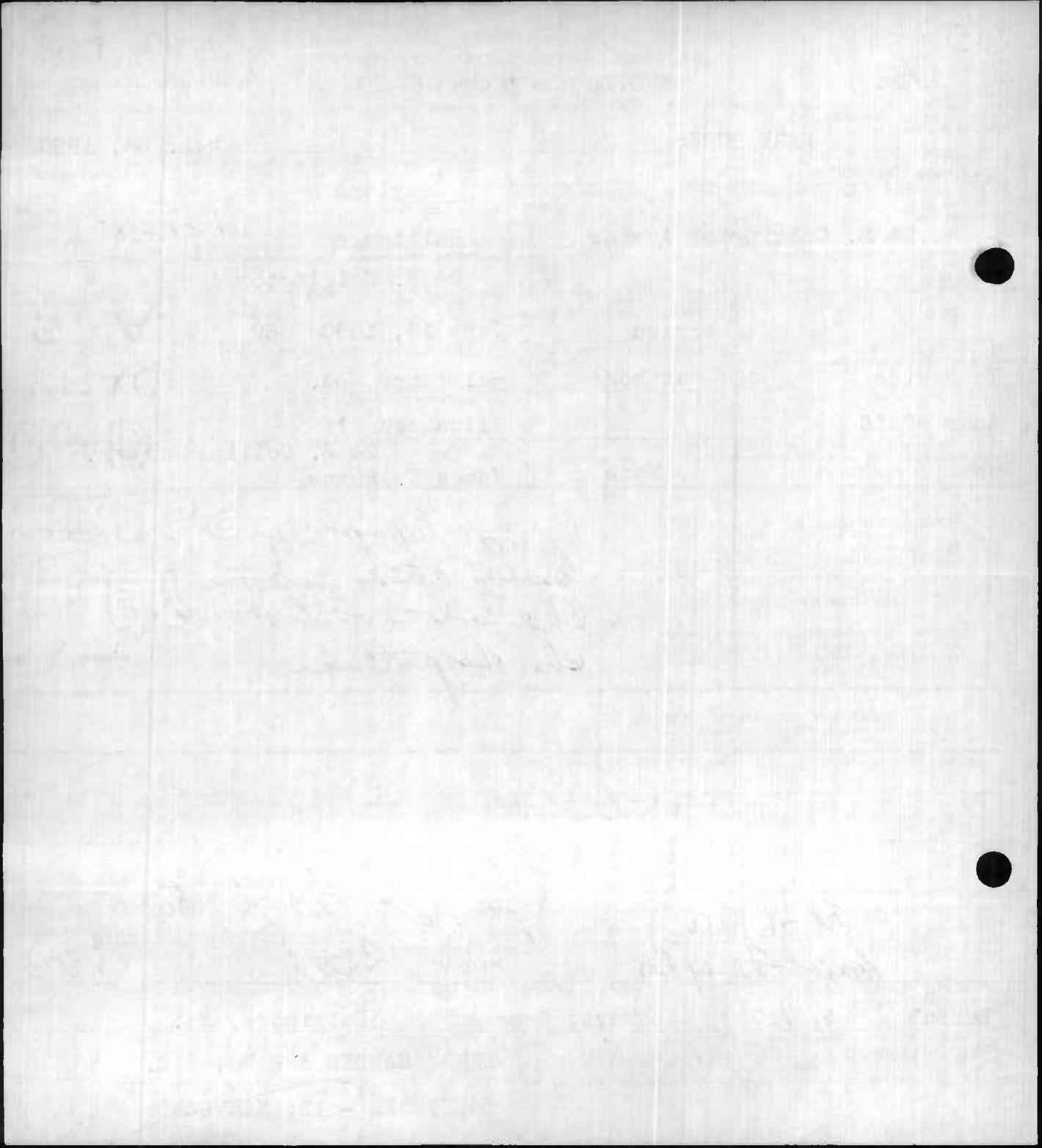
William H. Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.

ADDRESS

MEDICAL CERTIFICATION



320
50 1753

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

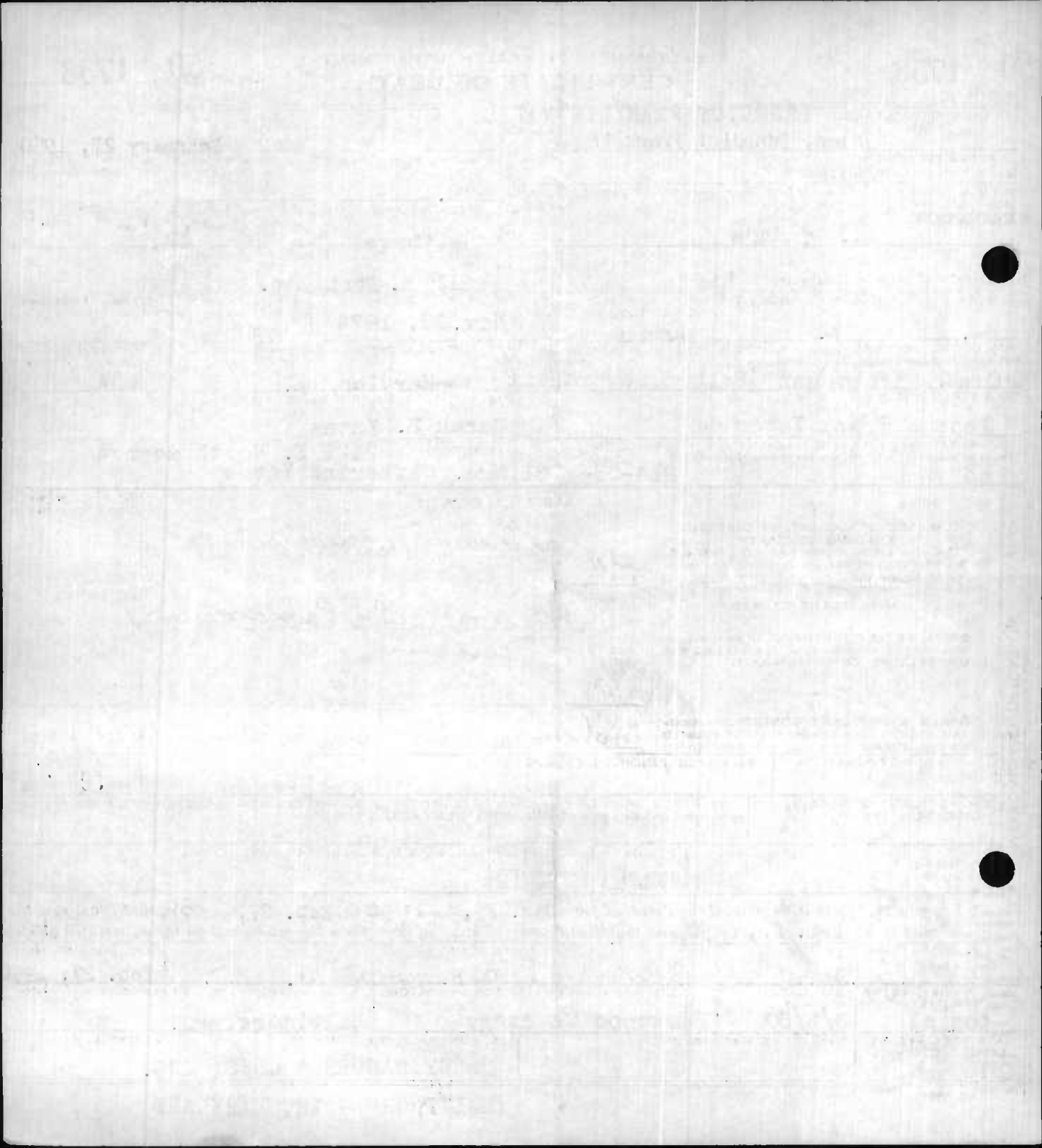
Registered No. 50 1753

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENEDICT FRANKLIN YATES Yates, Benedict Franklin		2. DATE OF DEATH February 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 8-02	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. LENGTH OF STAY IN BALTIMORE Life		D. STREET ADDRESS (If rural, give location) 2129 E. North Ave.	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 20, 1874
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Street man		9. AGE (In years last birthday) 75	
10B. KIND OF BUSINESS OR INDUSTRY Baltimore Transit		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Frank Yates	
14. MOTHER'S MAIDEN NAME Sarah P. Yates		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no	
16. SOCIAL SECURITY NO. 214-03-7821		17. INFORMANT 2129 E. North Avenue Mrs. Catherine Yates	

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac Decompensation		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic Cardio-vascular Disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus & Diabetic Gangrene (Rt foot)			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 29, 1950 to Feb. 27, 1950 , that I last saw the deceased alive on Feb. 26, 1950 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.			
23A. SIGNATURE S. K. Kaan		23B. ADDRESS M. D. 1100 N. Caroline St.	23C. DATE SIGNED Feb. 27, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 3/2/50	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1950		REGISTRAR'S SIGNATURE William	25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.



210

1754

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50

1754

1. NAME OF DECEASED (Type or Print) MARGARET ELIZABETH Bishop			2. DATE OF DEATH Feb. 26, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 517 507 BEAUMONT AVE			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-10		
C. Length of stay in Baltimore LIFE			D. STREET ADDRESS (If rural, give location) 504 CHATEAU AVE		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH NOV. 6, 1890	9. AGE (In years last birthday) 59	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME MICHAEL FRIEDEL			14. MOTHER'S MAIDEN NAME UNKNOWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Wm H. Bishop Jr.			ADDRESS 504 CHATEAU AVE		

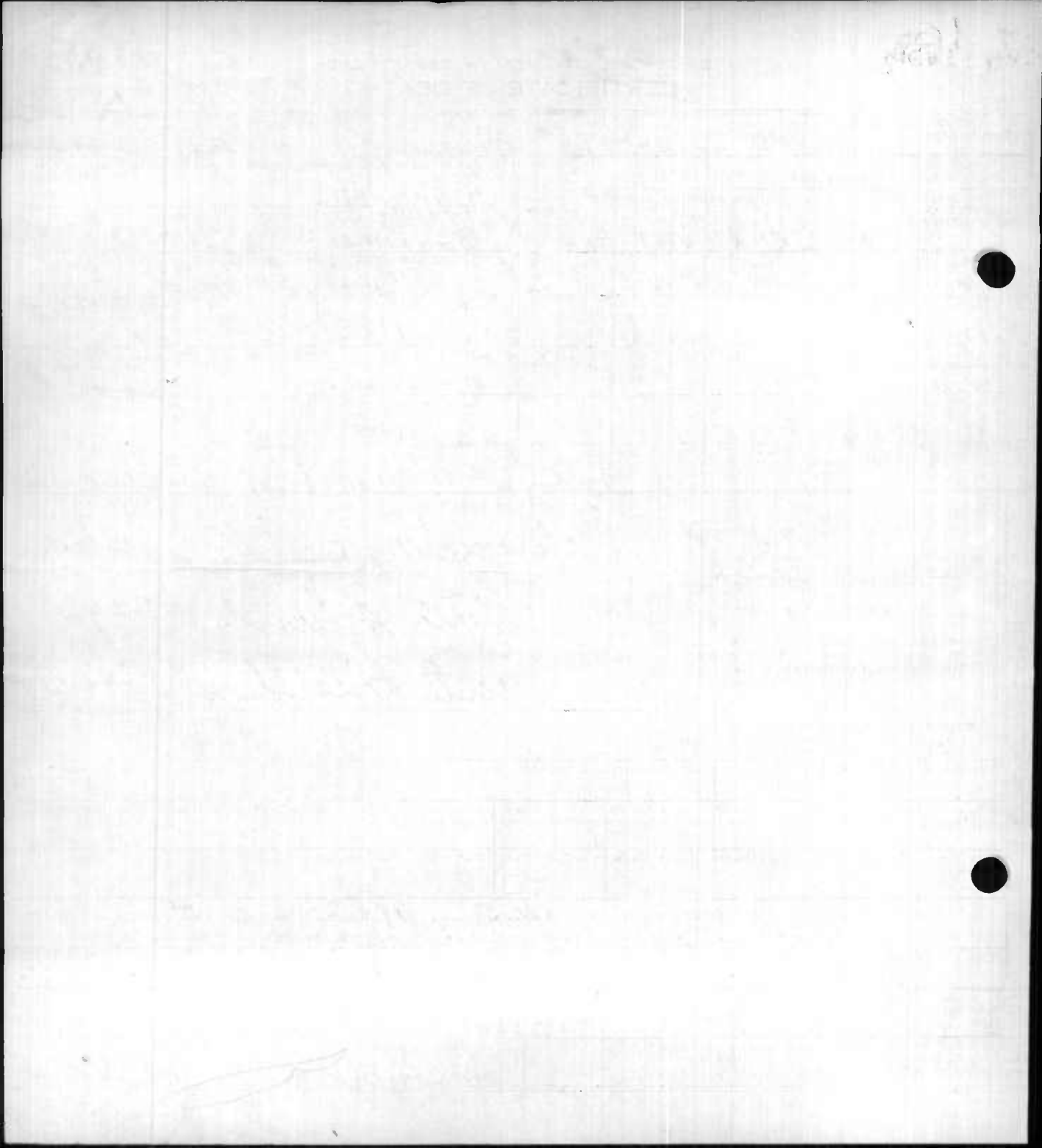
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic Myocarditis		2 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arterio Sclerosis		2 yrs.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Acute Dilatation		30 min.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec. 5, 1949, to 2-26, 1950, that I last saw the deceased alive on 2-25, 1950, and that death occurred at 11 P. M., from the causes and on the date stated above.

23A. SIGNATURE Indus. P. Blake	23B. ADDRESS Med. Arts Bldg.	23C. DATE SIGNED 2-27-50
--	--	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE MARCH 1st	24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER	24D. LOCATION (City, town, or county) (State) BALTIMORE MD
DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR John A. Moran
		ADDRESS 3000 E. Balto. Hs	



251
50 1755BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH587.2
50 1755

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10-27-48

9. AGE (In years last birthday)

11 Under 1 Year Months: Days Hours: Min.

16

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Condrey Higgenbotham

14. MOTHER'S MAIDEN NAME

Edith Wall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Severe Pulmonary Infection

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pancreatic Fibrosis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-11-1949 to 2-28-1950, that I last saw the deceased alive on 2-28-1950, and that death occurred at 2:10 a.m., from the causes and on the date stated above.

23A. SIGNATURE

James L. Gansler Jr. M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2-28-50

24C. NAME OF CEMETERY OR CREMATORY

ST. MARY'S

24D. LOCATION (City, town, or county)

ST. MARY'S La.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

John D. Mitchell & Sons

1900 Eutaw Pl.

1. The first thing I noticed when I stepped out of the plane was the cold air.

It was a sharp contrast to the warm air of the plane.

I had heard that the weather was bad, but I didn't expect it to be this cold.

I was told that the weather was bad, but I didn't expect it to be this cold.

I was told that the weather was bad, but I didn't expect it to be this cold.

I was told that the weather was bad, but I didn't expect it to be this cold.

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I was told that the weather was bad, but I didn't expect it to be this cold.

I was told that the weather was bad, but I didn't expect it to be this cold.

I was told that the weather was bad, but I didn't expect it to be this cold.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1756

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHRISTIAN KELLER

2. DATE
OF
DEATH

2-28-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

UNIVERSITY HOSP.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

W

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES
(Yes, or or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give
county and township)

D. STREET ADDRESS (If rural, give location)

2900

Strathmore Ave

8. DATE OF BIRTH

4-13-1875

9. AGE (In years,
last birthday)

74

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Balto Md

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Catherine Eberle

17. INFORMANT

ADDRESS

Mr. F. Keller - 2900 Strathmore

18.

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Pulmonary Embolism?
Coronary Thrombosis?
myocardial infarction?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

arteriosclerotic Heart Dis.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Bronchopneumonia

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-27-1950, to 2-28-1950, that I last saw the
deceased alive on 2-28-1950, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

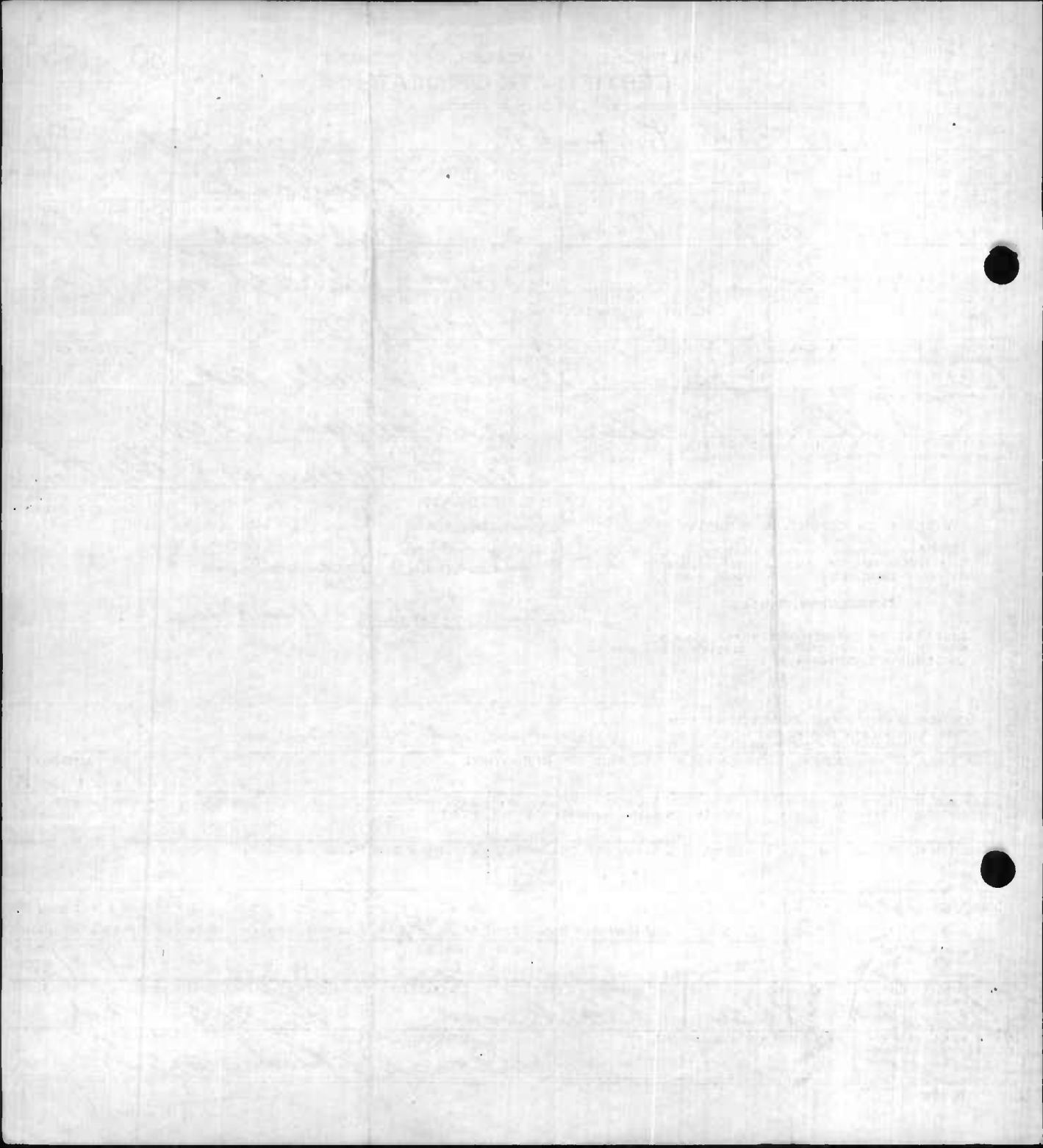
ADDRESS

FEB 28 1950

VS 150

27480

93D



220
50 1757BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1750 1757
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Tessie

No K's

2. DATE
OF
DEATH

Feb. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Pinecrest Nur. Home

4. USUAL RESIDENCE (Where deceased lived, if institution; residence, if not)
STATE B. COUNTY

Baltimore Md. 27-005

B. FULL NAME OF (If not in hospital or institution, give street address or location)
INSTITUTION

Pinecrest Sanatorium

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
3034 Pinewood Ave.D. STREET ADDRESS (If rural, give location)
T

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)
41If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
George Staveropoulos 3034 Pinewood

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) CANCER OF THE BODY OF THE 3 MONTHS
uterus with metastases
to the intestines
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February 25, 1950, to Feb. 26, 1950, that I last saw the deceased alive on Feb 26, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

1760

4810

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH

1914

WALKER

1-1

Walker, Wm. H.

1-1

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1758

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Alice Jones

2. DATE

OF

DEATH

2/27/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Balto. City**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR

INSTITUTION

1506 Jefferson Street

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto. City

O. STREET ADDRESS (If rural, give location)

1506 Jefferson Street

Length of stay in Baltimore

15 Yrs.

Yrs.

Mos.

Days

5. SEX

Female

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 19, 1896

9. AGE (in years last birthday)

53

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

A. A. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unkown

14. MOTHER'S MAIDEN NAME

Unkown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Asbury Jones 1506 Jefferson St

18. **331X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebral Hemorrhage.**

DUE TO

24 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Hypertension**

DUE TO

6 months

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **25 Feb, 1950**, to **27 Feb, 1950**, that I last saw the deceased alive on **27 Feb, 1950**, and that death occurred **10:30 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE

G. E. Sumrell

M. D.

23B. ADDRESS

171 Ringgold St.

23C. DATE SIGNED

2/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/4/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn A. A. Co Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

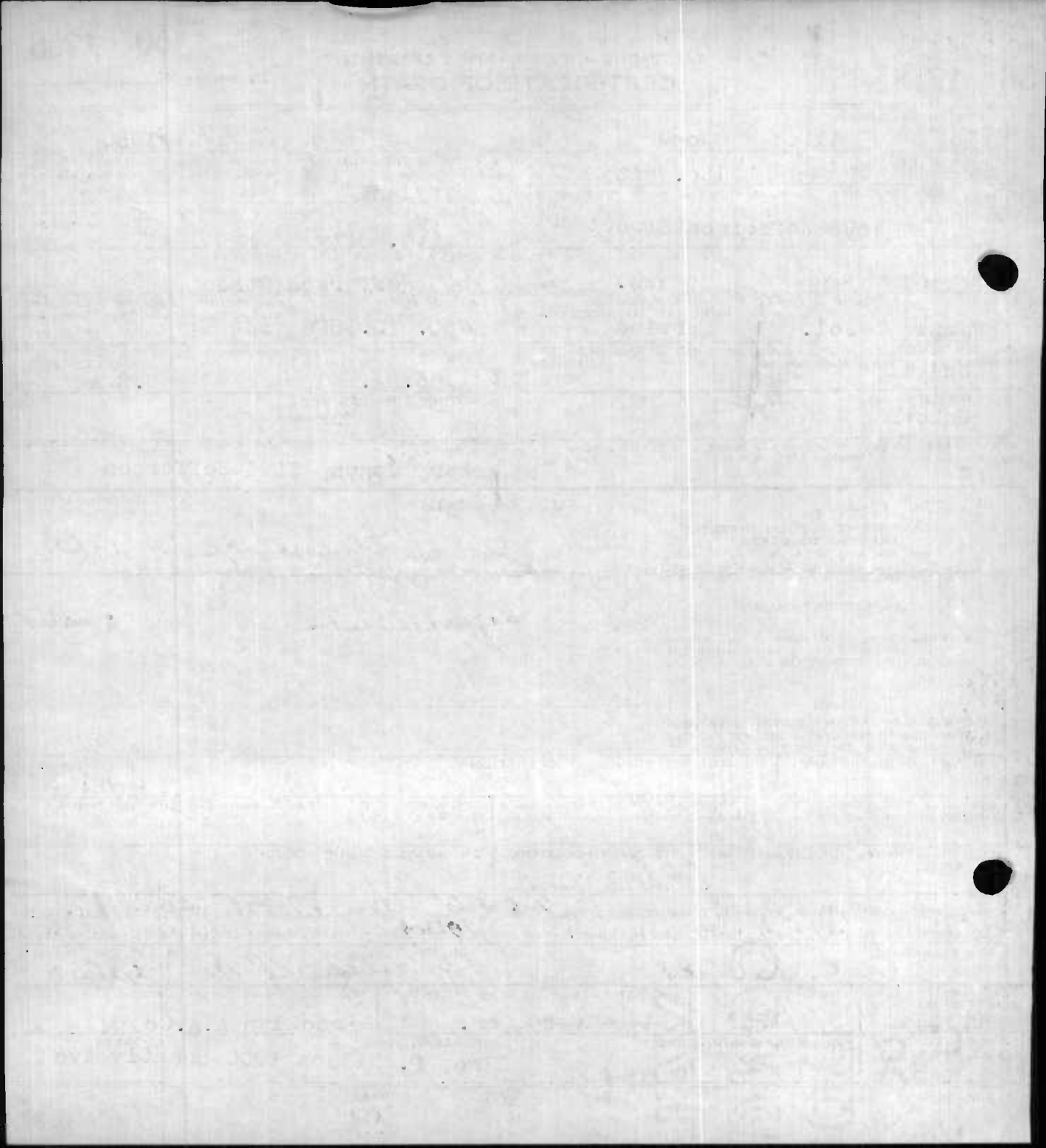
William Williams

25. FUNERAL DIRECTOR

ADDRESS

Elroy O. Wilson 1000 Brantly Ave

FEB 28 1950



263
50 1759BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1759
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sylvester J. Daugert		2. DATE OF DEATH Feb. 25th., 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2004 Christian Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-03	
C. Length of stay in Baltimore 12 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2004 Christian Street	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 23 1907
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur (Truck)		10B. KIND OF BUSINESS OR INDUSTRY Arundel Corp.	9. AGE (In years last birthday) 42
11. BIRTHPLACE (State or foreign country) Linden, N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Morris Daugert		14. MOTHER'S MAIDEN NAME Frances	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-12-1606	
17. INFORMANT		ADDRESS 2004 Christian St.	

18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.	CAUSE OF DEATH (A) Malignant Hypertension DUE TO with cerebral hemorrhage (B) none DUE TO (C) none	INTERVAL BETWEEN ONSET AND DEATH 3 max
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/21, 1950, to 2/25, 1950, that I last saw the deceased alive on 2/25, 1950, and that death occurred at 8 P. m., from the causes and on the date stated above.

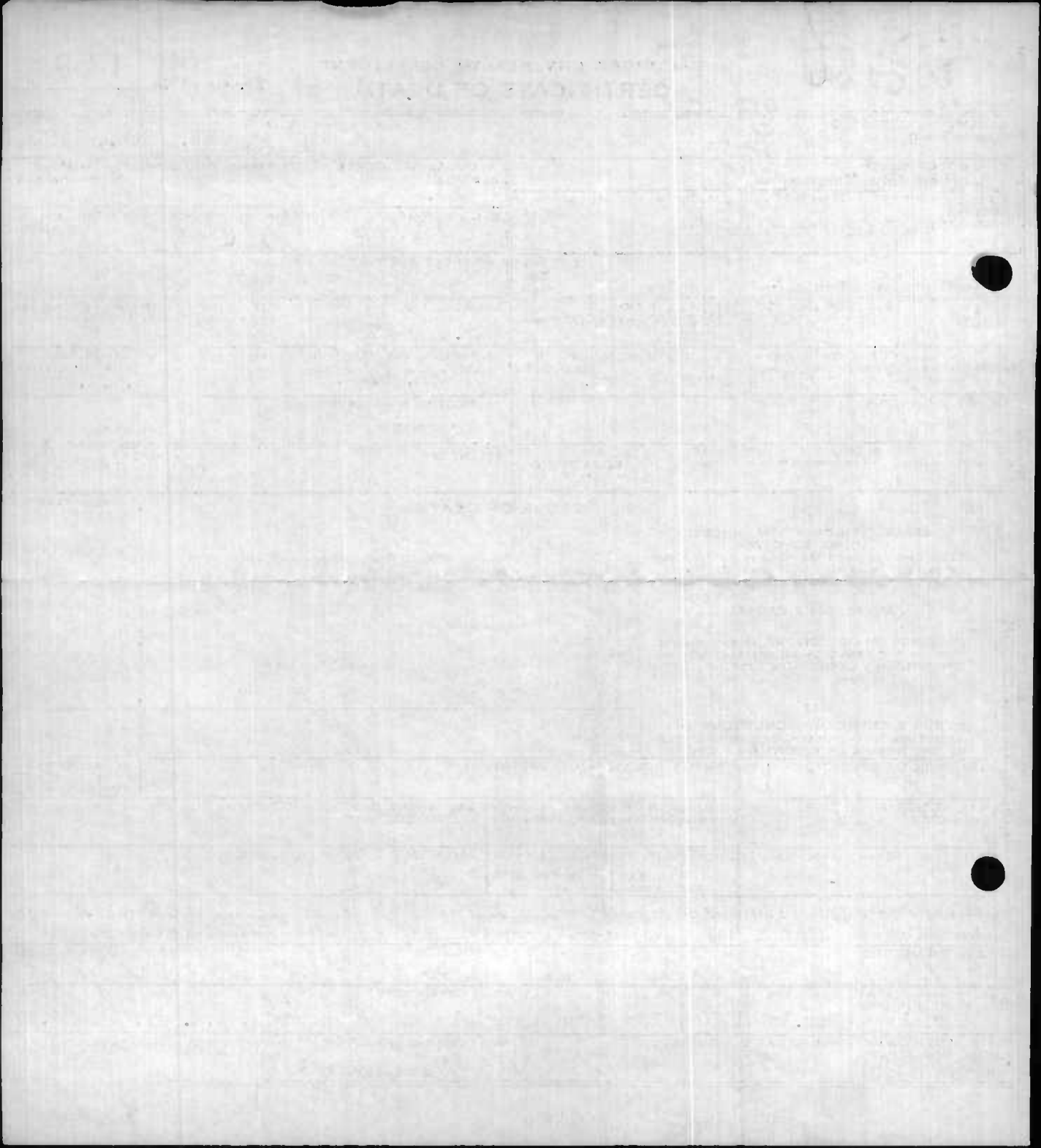
23A. SIGNATURE R. J. Miller M.D.	23B. ADDRESS 30 Wilkens Ave.	23C. DATE SIGNED 4/7/50
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24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Mar. 1st 1950	24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Cem	24D. LOCATION (City, town, or county) (State) Glenburnie, A.A.Co., Md.
---	----------------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR FEB 28 1950	REGISTRAR'S SIGNATURE [Signature]	FUNERAL DIRECTOR [Signature]	ADDRESS 4510 Liberty Heights Ave
---	--------------------------------------	---------------------------------	-------------------------------------

420 73 6 2

83a



425
50 1760BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1760

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MARY POWELL NELSON

2. DATE
OF
DEATH

Feb. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

3906 Dorchester Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3906 Dorchester Rd.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

June 26, 1854

9. AGE (In years
last birthday)

95

10. Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Balto. Co., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George H. Cole

14. MOTHER'S MAIDEN NAME

Elizabeth Amoss

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Kenneth K. Moore-3906 Dorchester Rd.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *Myocardial infarction*
DUE TO

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Arteriosclerosis*
DUE TO

20 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from *March 1, 1948* to *Feb 27, 1950* that I last saw the
deceased alive on *Feb 27, 1950*, and that death occurred at *12:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/2/50

Black Rock Cem.

Black Rock, Balto. Co., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950

WM. J. TICKNER & SONS

Balto., Md.

VS 150

93D

653
50 1761BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1761
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Joseph</u>		<u>HROMADKA</u>		2. DATE OF DEATH <u>February 27 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>2437 Jefferson St.</u>					
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>2437 Jefferson Street</u>					
C. Length of stay in Baltimore <u>46 yrs.</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter Carrier</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postal</u>			
13. FATHER'S NAME <u>Charles Hromadka</u>			14. MOTHER'S MAIDEN NAME <u>Anna Vyskocil</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or oooooo) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert Hromadka</u>	
				ADDRESS <u>Appt. A, 5714 Beechdale Dr.</u>	

18. 153X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) Adenocarcinoma of lower bowel with metastases to liver and peritoneum6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

(C)

19A. DATE OF OPERATION <u>December, 1949</u>		19B. MAJOR FINDINGS OF OPERATION <u>obstructive cancer of lower bowel with metastases to liver</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 31, 1947, to Feb. 27, 1950, that I last saw the deceased alive on Feb 26, 1950, and that death occurred at 1:30 A m., from the causes and on the date stated above.

23A. SIGNATURE <u>Melvin W. Borden</u>		23B. ADDRESS <u>2030 W. Fayette St</u>		23C. DATE SIGNED <u>2/27/50</u>	
---	--	---	--	------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3-2-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Ind.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>FEB 28 1950</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Williams</u>		25. FUNERAL DIRECTOR <u>Frank Crach</u>		ADDRESS <u>200 N. Chestnut St.</u>	

STATE OF NEW YORK
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Occupation		7. Cause of Death		8. Place of Death	
9. Name of Physician		10. Name of Undertaker		11. Name of Burial Place		12. Name of Cemetery	
13. Name of Registrar		14. Name of Coroner		15. Name of Medical Examiner		16. Name of Health Officer	
17. Name of Funeral Home		18. Name of Burial Place		19. Name of Cemetery		20. Name of Interment	
21. Name of Burial Place		22. Name of Cemetery		23. Name of Interment		24. Name of Burial Place	
25. Name of Cemetery		26. Name of Interment		27. Name of Burial Place		28. Name of Cemetery	
29. Name of Interment		30. Name of Burial Place		31. Name of Cemetery		32. Name of Interment	
33. Name of Burial Place		34. Name of Cemetery		35. Name of Interment		36. Name of Burial Place	
37. Name of Cemetery		38. Name of Interment		39. Name of Burial Place		40. Name of Cemetery	
41. Name of Interment		42. Name of Burial Place		43. Name of Cemetery		44. Name of Interment	
45. Name of Burial Place		46. Name of Cemetery		47. Name of Interment		48. Name of Burial Place	
49. Name of Cemetery		50. Name of Interment		51. Name of Burial Place		52. Name of Cemetery	
53. Name of Interment		54. Name of Burial Place		55. Name of Cemetery		56. Name of Interment	
57. Name of Burial Place		58. Name of Cemetery		59. Name of Interment		60. Name of Burial Place	
61. Name of Cemetery		62. Name of Interment		63. Name of Burial Place		64. Name of Cemetery	
65. Name of Interment		66. Name of Burial Place		67. Name of Cemetery		68. Name of Interment	
69. Name of Burial Place		70. Name of Cemetery		71. Name of Interment		72. Name of Burial Place	
73. Name of Cemetery		74. Name of Interment		75. Name of Burial Place		76. Name of Cemetery	
77. Name of Interment		78. Name of Burial Place		79. Name of Cemetery		80. Name of Interment	
81. Name of Burial Place		82. Name of Cemetery		83. Name of Interment		84. Name of Burial Place	
85. Name of Cemetery		86. Name of Interment		87. Name of Burial Place		88. Name of Cemetery	
89. Name of Interment		90. Name of Burial Place		91. Name of Cemetery		92. Name of Interment	
93. Name of Burial Place		94. Name of Cemetery		95. Name of Interment		96. Name of Burial Place	
97. Name of Cemetery		98. Name of Interment		99. Name of Burial Place		100. Name of Cemetery	

520
50 1762BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1762

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Julia V. Johanne

2. DATE
OF
DEATH

Feb. 26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2247 McEldery St.

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. 7-03

D. STREET ADDRESS (If rural, give location)

2247 McEldery St.

Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Sept. 16-1884

9. AGE (In years last birthday)

65

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Finerty

14. MOTHER'S MAIDEN NAME

Mary Riley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Ida M. Johanne

ADDRESS

2247 McEldery St.

18. 581.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Chronic congestive heart failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Arteriosclerotic cardiovascular disease

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Cirrhosis of liver

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

26 Feb 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Mar. 1-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

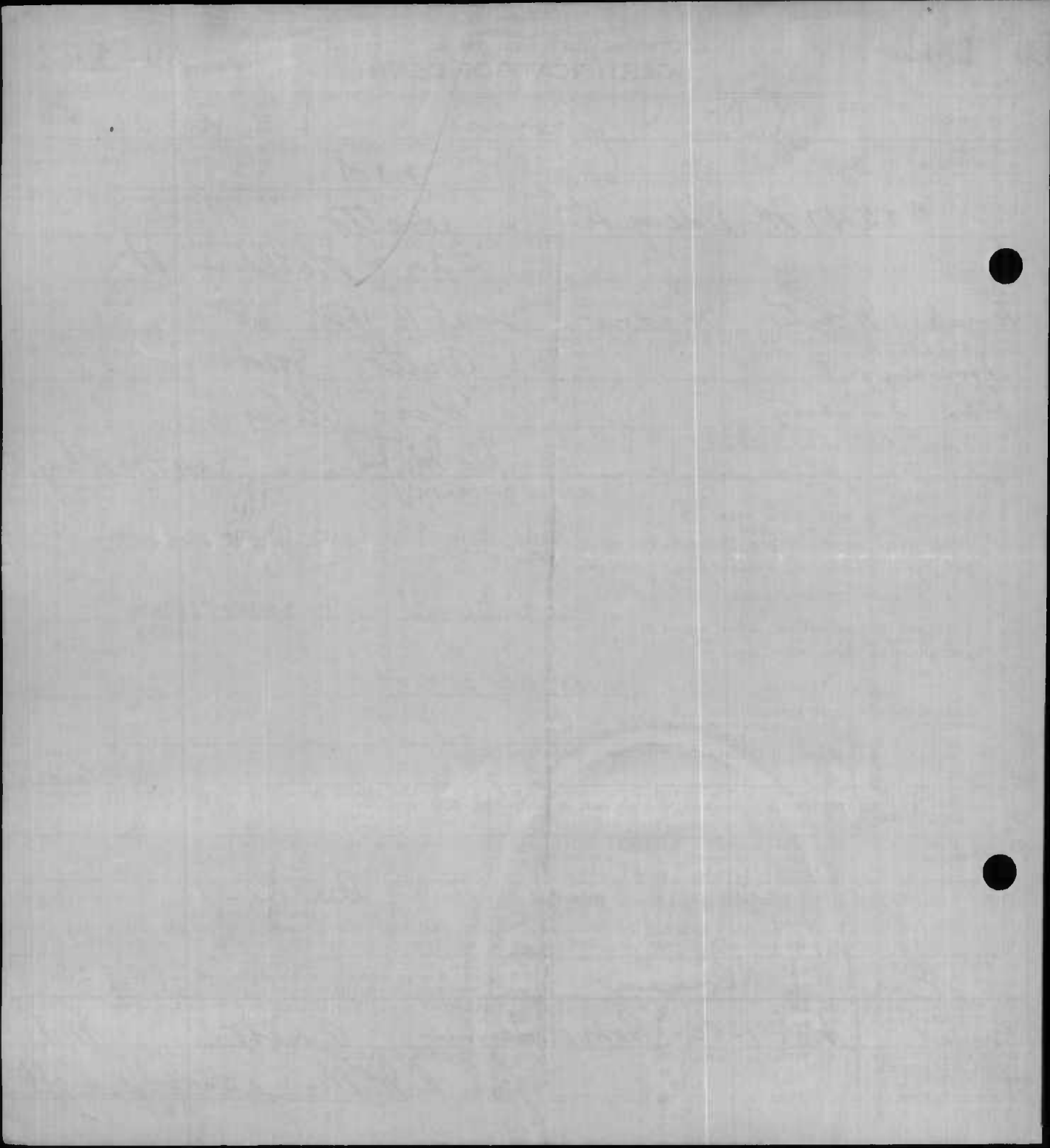
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

FEB 28 1950



100
50 1763BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1763

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mrs. Laura Roop</i>			2. DATE OF DEATH <i>2/28/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Fredrick</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Fredrick</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>New Market.</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>11/1884</i>	9. AGE (In years last birthday) <i>65</i>	II Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Huf.</i>			11. BIRTHPLACE (State or foreign country) <i>PA.</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>L. Simpson</i>			14. MOTHER'S MAIDEN NAME <i>Ella Francis</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Dr. Roop (son)</i>			ADDRESS		

18. <i>540.0</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Bleeding Peptic Ulcer</i>	
ANTECEDENT CAUSES	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II	(C) <i>Arteriosclerosis, generalized</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1/15/50*, 19*50*, to *2/28/50*, 19*50*, that I last saw the deceased alive on *Feb. 28*, 19*50*, and that death occurred at *7:00 p.m.*, from the causes and on the date stated above.

23. SIGNATURE *John H. Banzarek* M. D. ADDRESS *Mercy Hosp.* 23C. DATE SIGNED *2/28/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-2-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Fredrick - Md.</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 1 1950</i>	REGISTRAR'S SIGNATURE <i>John H. Banzarek</i>	25. FUNERAL DIRECTOR <i>C. E. Cling & Son</i>	ADDRESS <i>Fredrick - Md.</i>
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STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY

11

50 1764

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1764

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SUSIE GRIFFITH

2. DATE
OF
DEATH

Feb. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2608 Guilford Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 12-03

D. STREET ADDRESS (If rural, give location)

2608 Guilford Ave

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

June 1, 1876

9. AGE (In years
last birthday)

73

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Caroline Co., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas Trice

14. MOTHER'S MAIDEN NAME

Sarah (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

John A. Griffith, 2608 Guilford Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis
Coronary Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension
Generalized arteriosclerosis
Anteriorly located C-V Disease

(C) DUE TO

3 yrs.

3 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Pleurisy

3 weeks

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1947 to Feb. 21, 1950 that I last saw the
deceased alive on Feb. 21, 1950 and that death occurred at 2 P. m., from the causes and on the date stated above.

23A. SIGNATURE

K. Krulevitz

23B. ADDRESS

244 W. Hilton St

23C. DATE SIGNED

2/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill

24D. LOCATION (City, town, or county)

Towson, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

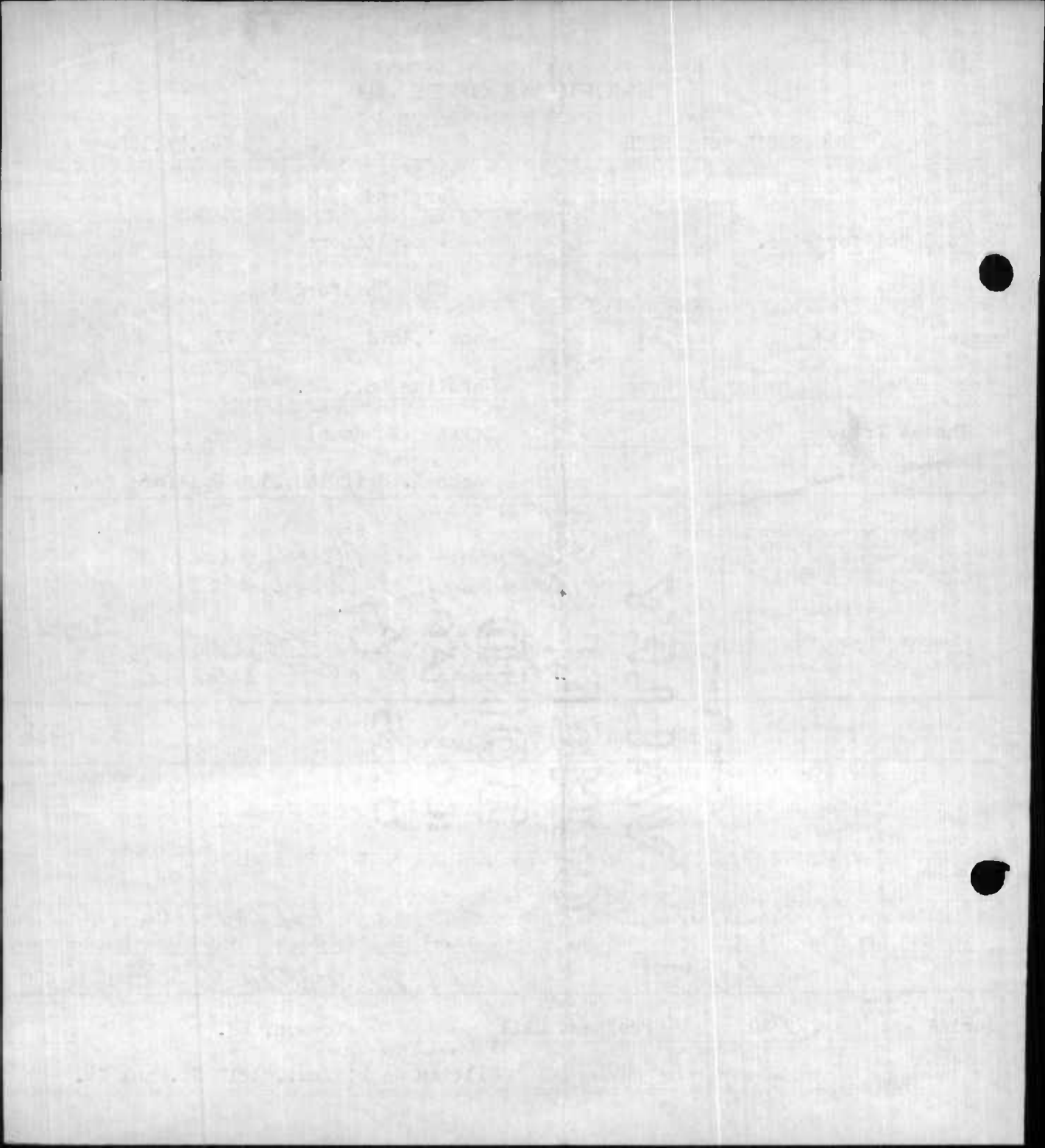
REGISTRAR'S SIGNATURE

William Cook, Inc.

25. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul St.



50 1765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1765

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES KERR

2. DATE
OF
DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

New York

5. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Johns Hopkins Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

New York

D. STREET ADDRESS (If rural, give location)

212 E. 117th Street

Length of stay in Baltimore

Yrs.
Mos.
Days

9. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
109-05-2226

17. INFORMANT

ADDRESS

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

18. E851.X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Drowning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

boat

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? In stream off Sparrows Point
freighter "African Enterprise" Ore21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

February 27, 1950 7 a.m.

21E. INJURY OCCURRED
WHILE AT ☒ NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

rod supporting plank slipped) into water
Accidentally fell off gangway plank22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Feb. 27, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 151

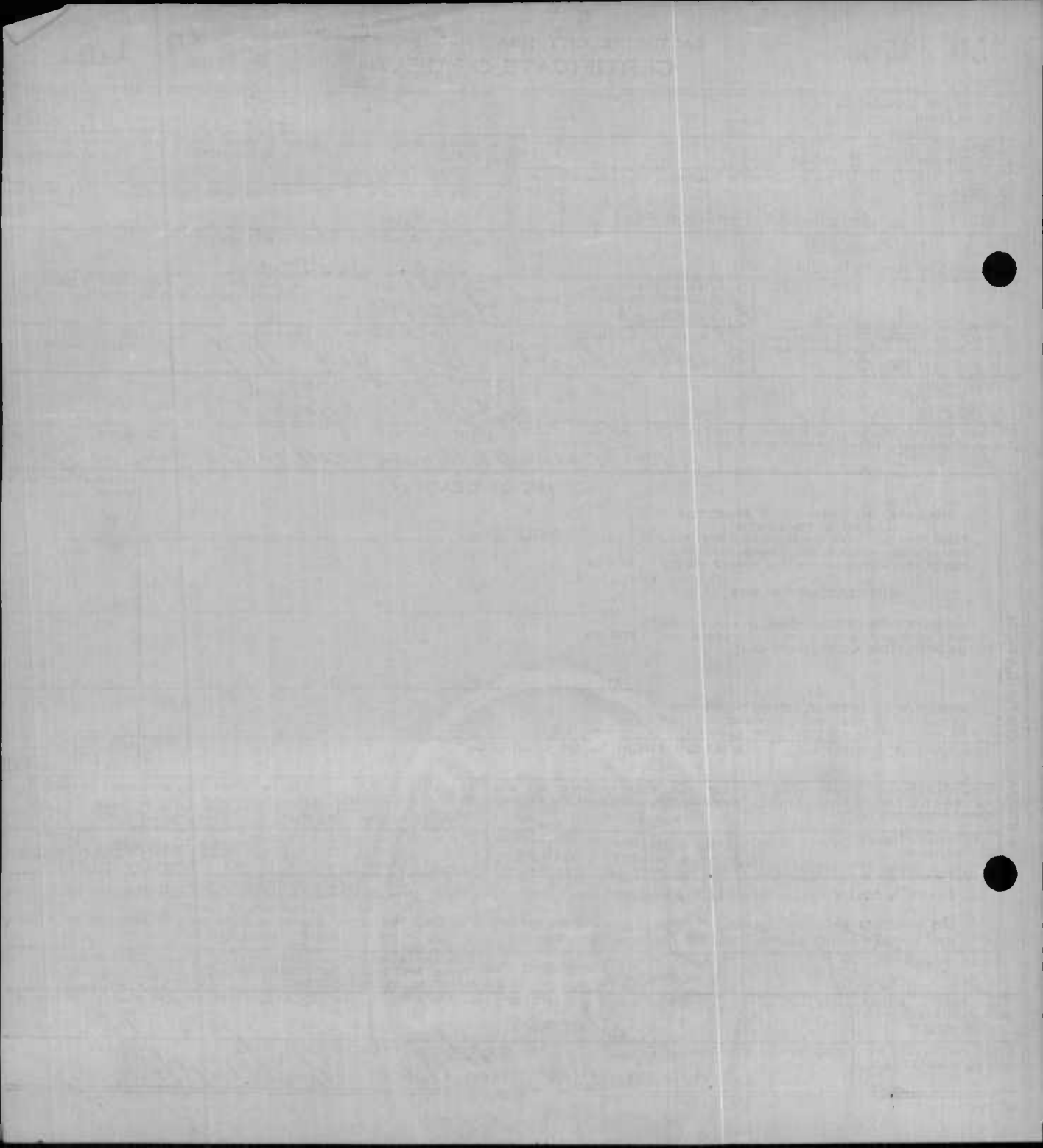
N-990.X

46051

183

V

MEDICAL CERTIFICATION



BIRTH NO. 50 1766		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 50 1766	
1. NAME OF DECEASED (Type or Print) LAYTON G. GRAYBILL GRABILL			2. DATE OF DEATH Feb. 28, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION West Baltimore General Hospital Length of stay in Baltimore			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-17 D. STREET ADDRESS (If rural, give location) 3328 Heyward Ave.		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 3-4-1899	9. AGE (In years last birthday) 50	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Balt Mar Corp.	11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John D. Grabill		14. MOTHER'S MAIDEN NAME Mary E. Rout		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ? ?	
16. SOCIAL SECURITY NO. 217-14-2958		17. INFORMANT Edna Grabill		3328 Heyward Ave. Balt. Md.	
18. E976 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of brain DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH Interval BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3328 Heyward Ave.	
21D. TIME (Month) (Day) (Year) (Hour) Feb. 27, 1950 7:45 A		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR? Firearms	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE R. H. Fisher		23B. CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER MEDICAL INVESTIGATOR		23C. DATE SIGNED Feb. 28, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-3-50		24C. NAME OF CEMETERY OR CREMATORY Union Chapel	
24D. LOCATION (City, town, or county) Libertytown, Md.		24E. FUNERAL DIRECTOR C. H. W. - Lykensville, Md.		24F. ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1950		REGISTRAR'S SIGNATURE William W. ...		ADDRESS	
VS 151 N-853.4 32637 164c V					

STATE OF NEW YORK
COUNTY OF ALBANY

50 1767

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1767
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Israel (Graff) GRAFF

2. DATE
OF
DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Washington D.C.

D. STREET ADDRESS (If rural, give location)

4222 14th St. N.W.

Length of stay in Baltimore

35

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9-3-03

9. AGE (In years last birthday)

46

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR INDUSTRY

Delecatessian

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

not known

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 464 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Pulmonary embolus

5 min

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Thrombophlebitis

2 mos

DUE TO

Carcinoma of the stomach

2 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2-9, 1950, to 2-27, 1950, that I last saw the deceased alive on 2-27, 1950, and that death occurred at 7:35 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Ernest C. Brown Jr.

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

2-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-1-50

24C. NAME OF CEMETERY OR CREMATORY

United Hebrew

24D. LOCATION (City, town, or county) (State)

Balto Md

DATE RECEIVED BY LOCAL REGISTRAR

MARCH 1 1950

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Jack Lewis Inc 2100 Canton Rd

ADDRESS

Thayer v

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anna Mae Payne

2. DATE

OF DEATH

2-27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE Baltimore City Hospitals
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 22-01D. STREET ADDRESS (If rural, give location)
712 S. Charles St. Zone 30

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single

8. DATE OF BIRTH

Nov. 3, 1915

9. AGE (In years last birthday)

34

If Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Callie

14. MOTHER'S MAIDEN NAME

Mattie Carter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Baltimore City Hospitals
Records--4940 Eastern Ave.

18. 002.X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis with terminal hemorrhage.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2-16-1950 to 2-27-1950, that I last saw the deceased alive on 2-27-1950, and that death occurred at 2:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

B. C. H. - 4940 Eastern Ave.

2-28-1950.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 1 1950

Wm. J. Williams

James A. Hayes

638 4.9th St

VS 150

1950 00001771

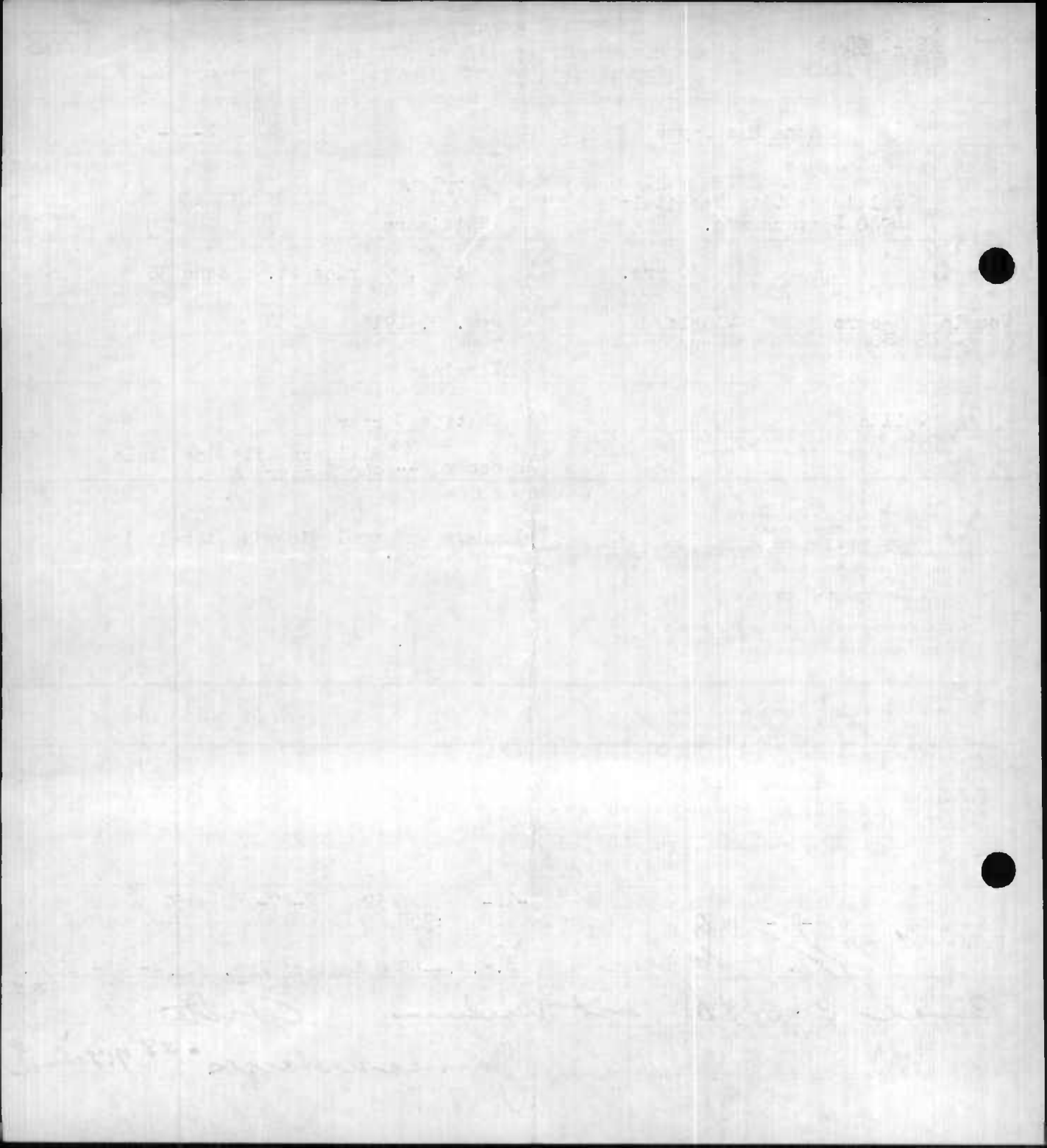
130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1768

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

STATE OF NEW YORK

County of _____

On this _____ day of _____

at _____

I, _____

do hereby certify that _____

was born on _____

at _____

and died on _____

at _____

from _____

caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

and the death was caused by _____

WILSON
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1770

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Roland Wilson

2. DATE
OF
DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE *md.* B. COUNTY *26-06*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore GROUSE

D. STREET ADDRESS (If rural, give location)
5603 Morse Court

Length of stay in Baltimore
Yrs. Mos. Days

5. SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

Dec. 4/1892

9. AGE (In years, last birthday)

57

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
laborer

10B. KIND OF BUSINESS OR INDUSTRY
Contractor

11. BIRTHPLACE (State or foreign country)
S.C.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME
unknown

14. MOTHER'S MAIDEN NAME
unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no none

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
JOHNS HOPKINS HOSPITAL

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *myocardial infarction*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *arteriosclerotic cardiovascular disease & congestive*
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *failure & auricular fibrillation*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2-27*, 19*50*, to *2-27*, 19*50*, that I last saw the deceased alive on *2-27*, 19*50*, and that death occurred at *9:27* p.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

2/28/50

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/4/50

mt Calvary

Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 1 1950

Wm. J. Williams

A. J. Fulestad - Cedar Hill

VS 150

To be approved by Med Examiner 988V9

OVER - 937

MEDICAL CERTIFICATION

NOT A MEDICAL EXAMINER'S CASE

R. S. Fisher, M.D.

CHIEF OF ALST. MEDICAL EXAMINER

per: Jgm

536
50 1771BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1771
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Wm. J. Wender

2. DATE
OF
DEATH

2/25/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Crookston Hospital

Length of stay in Baltimore

3 Yrs.
Mos.
Days

3. SEX

M.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

unemployed

13. FATHER'S NAME

Sam. W. Wender

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL
SECURITY NO.

none

4. USUAL RESIDENCE (Where deceased lived, If institution: residence
A. STATE B. COUNTY before admission)

Md.

City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 1104

D. STREET ADDRESS (If rural, give location)

1226 - McCulloch St.

8. DATE OF BIRTH

Nov. 5, 1946

9. AGE (In years
last birthday)

3

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Jessie Perkins

17. INFORMANT

Sam. Wender - McCulloch St.

18. E 883.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(A)

DUE TO

Generalized peritonitis
Rupture of stomach
Lye poisoning

(B)

DUE TO

(C)

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1226 McCulloch Street

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

2-16-50 App. 3 p. m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Ingestion of lye

22. I certify that I took charge of the remains described above, held an _____ thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

E. L. Royer

23B. CHIEF MEDICAL EXAMINER.....

23C. DATE SIGNED

MEDICAL INVESTIGATOR.....

#26 Feb 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county) (State)

Cedar Hill Md.

DATE RECEIVED BY
LOCAL REGISTRAR

MAR 1 1950

REGISTRAR'S SIGNATURE

T. W. Williams, Jr.

25. FUNERAL DIRECTOR

W. Halsted - 918 -

ADDRESS

1792

CERTIFICATE OF DEATH



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1772
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Emma Elizabeth Hoover</i>		2. DATE OF DEATH <i>February 28, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Pa.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Chambersburg</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>Rural Route # 3</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3-7-66</i>
9. AGE (In years last birthday) <i>83</i>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Shippensburg, Pa.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Shoap</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Ann Heberlig</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebrovascular Accident</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
DUE TO (A)		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Cerebral arteriosclerosis</i>		DUE TO (B)
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Coronary artery Sclerosis</i>		DUE TO (C)
19A. DATE OF OPERATION <i>2-18</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>2-18</i> , 19 <i>50</i> , to <i>2-28</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>2-28</i> , 19 <i>50</i> , and that death occurred at <i>11:20 P.M.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>John M. Pans</i>	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	24B. DATE <i>3/1/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Norland Cem.</i>
24D. LOCATION (City, town, or county) <i>Chambersburg, Pa.</i>		(State)
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 1 1950</i>	REGISTRAR'S SIGNATURE <i>William J. Tickner</i>	25. FUNERAL DIRECTOR <i>WM. J. TICKNER & SONS</i>
		ADDRESS <i>Balto., Md.</i>

RECEIVED



146
50 1773BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1773
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MATILDA WILHELMINE (TILLIE) EBELER

2. DATE
OF Feb. 27, 1950
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4515 Garrison Blvd.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4206 N. Rogers Ave.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 25, 1879

9. AGE (In years
last birthday)

70

10. Under 1 Year
Months Days
11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Never Employed

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ernest H. Ebeler

14. MOTHER'S MAIDEN NAME

Matilda Louisa Bohne

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Mr. Harry Ebeler 4026 N. Rogers Ave.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral Vase Accidents
DUE TO3 Mos
6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Arteriosclerotic Cardio Vase
DUE TO

Arteriosclerotic Cardio Vase

6 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C) Secondary Arteriosclerosis
DUE TO

Secondary Arteriosclerosis

20. AUTOPSY?
YES ☐ NO ☐

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1946 to Feb 27, 1950 that I last saw the deceased alive on 2-27-1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

St. Paul's Cem.

24D. LOCATION (City, town, or county) (State)

Druid Hill Pk., Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

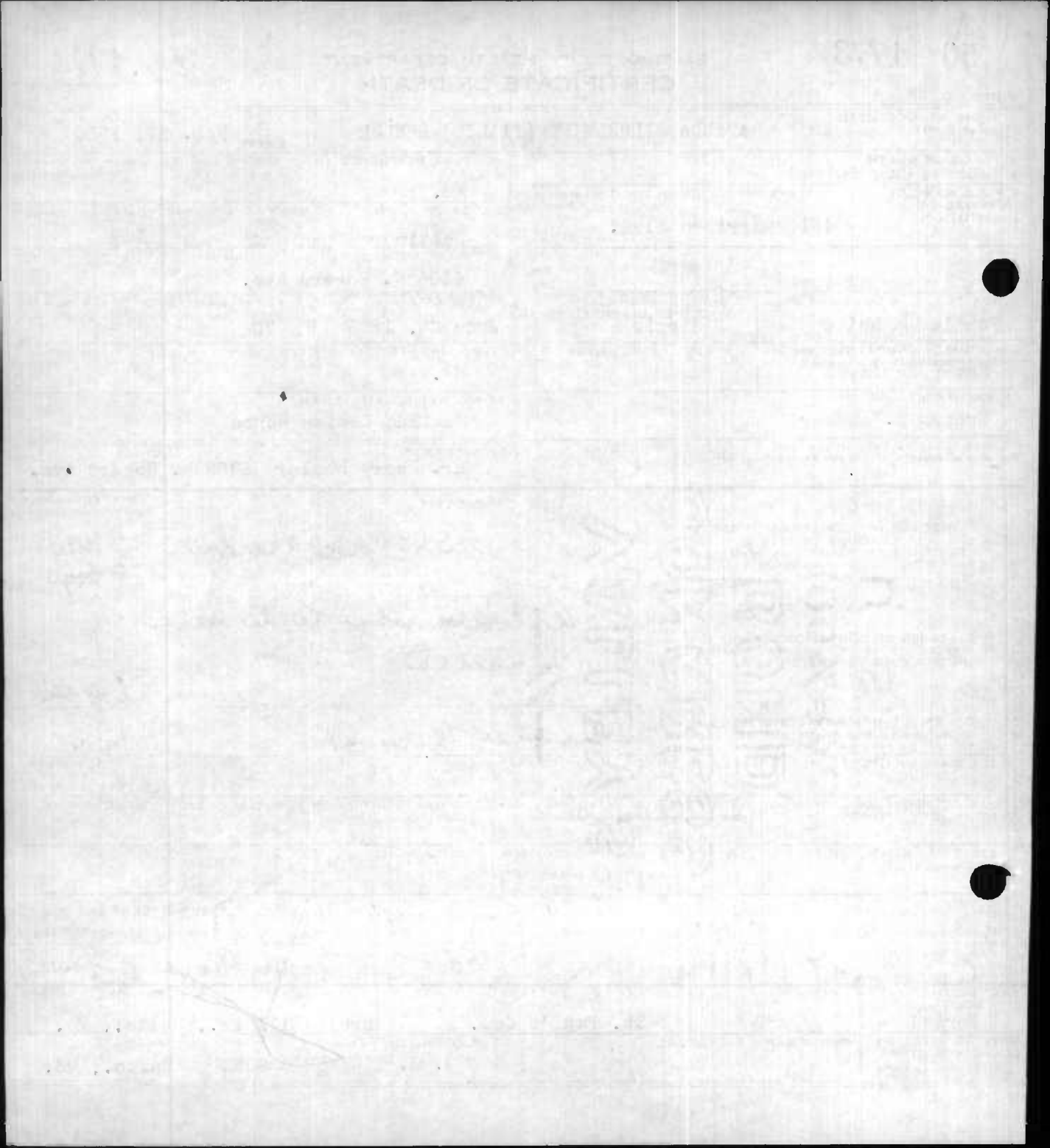
25. FUNERAL DIRECTOR

ADDRESS

MAR 1 1950

WM. J. TICKNER & SONS

Balto., Md.



-352
50 1774BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1774
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JENNIE G. WHITTINGTON			2. DATE OF DEATH Feb. 26.1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
5. FULL NAME OF HOSPITAL OR INSTITUTION 613 W. LAFAYETTE AVENUE			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 14-02		
Length of stay in Baltimore Life Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 613 West Lafayette Avenue		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 16, 1870	9. AGE (In years last birthday) 79	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Garrett			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----	17. INFORMANT ADDRESS H.A. Whittington-613 W. Lafayette A		

18. 443. X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) cerebral thrombosis DUE TO (B) hypertensive cardio-vascular disease with arterial sclerosis DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 67 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION none	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1 Feb.**, 1950, to **26 Feb.**, 1950, that I last saw the deceased alive on **26 Feb.**, 1950, and that death occurred at **2:30** p. m., from the causes and on the date stated above.

23A. SIGNATURE James P. Carr	23B. ADDRESS 1427 Madison Ave	23C. DATE SIGNED 2.27.50
--	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/1/50	24C. NAME OF CEMETERY OR CREMATORY MOUNT AUBURN CEMETERY	24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND
DATE RECEIVED BY LOCAL REGISTRAR MAY 1 1950		REGISTRAR'S SIGNATURE William H. Williams	25. FUNERAL DIRECTOR ADDRESS THE CHARLES R. LAW MORTUARY

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[The remainder of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a memorandum or report, but the specific details cannot be discerned.]

600
50 1775BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1775

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

TORALF JOHAN KRISTIANSEN FUHR

2. DATE
OF
DEATH

FEB. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE La.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR US Marine Hospital
INSTITUTION

Wyman Pk. Drive & 31st St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
New Orleans

D. STREET ADDRESS (If rural, give location)

4106 St. Claude Ave.

Length of stay in Baltimore

1

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

B. DATE OF BIRTH

5/6/96

9. AGE (In years
last birthday)

53

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
Chief mate10B. KIND OF BUSINESS OR
INDUSTRY
Seafarer

11. BIRTHPLACE (State or foreign country)

Norway

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Kristian Enoksen

14. MOTHER'S MAIDEN NAME

Kirsten Tobiasen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL

SECURITY NO.
438-20-7475

17. INFORMANT

ADDRESS

Records- US Marine Hospital, Balto, Md.

18.

157X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of head of pancreas with
metastasis to liver; with jaundice
and duodenal obstruction.
DUE TO

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Peritonitis, acute, terminal
DUE TO

Few days

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 3, 1950, to Feb. 28, 1950, that I last saw the
deceased alive on Feb. 28, 1950, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE

John L. Wilson, Medical Director

M. D.

23B. ADDRESS

US Marine Hospital, Balto, Md.

23C. DATE SIGNED

2/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3-2-1950

24C. NAME OF CEMETERY OR CREMATORY

St Peter's Cemetery - Burlew's Lane

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, Jr.

25. FUNERAL DIRECTOR

ADDRESS

Earl B. Wolbertson 403-E-25th St.

VS 150

13051776

469

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1

2/1/30

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

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11-11-11

11-11-11

For Approval of Med. Examiner!

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 1776

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mrs. Elizabeth Heck

2. DATE
OF
DEATH

February 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 20-08

D. STREET ADDRESS (If rural, give location)

299 South London Ave

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

5-23-1871

9. AGE (In years last birthday)

78

10. Under 1 Year Months: Days

9

11. Under 24 Hours Hours: Min.

7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry - MEYER

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

W. Heck Sr

ADDRESS

Same

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Left lobar Pneumonia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Anterior - scler. C.V.D.

DUE TO

(C)

CERTIFICATION APPROVED BY

for C. J. Lubinski, M.D.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fract. neck rt. Humerus.

CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

224 S. London Ave.

21D. TIME (Month) (Day) (Year) (Hour)

2-10-50

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pt. fell -- Slipped and fell to floor

22. I hereby certify that I attended the deceased from 2-10-50 to 2-25-50, that I last saw the deceased alive on 2/25/50 and that death occurred at 7:00 PM from the causes and on the date stated above.

23A. SIGNATURE

Curtis T. Hall Jr.

23B. ADDRESS

St. Agnes Hosp.

23C. DATE SIGNED

2-25-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/1/50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MARCH 1950

REGISTRAR'S SIGNATURE

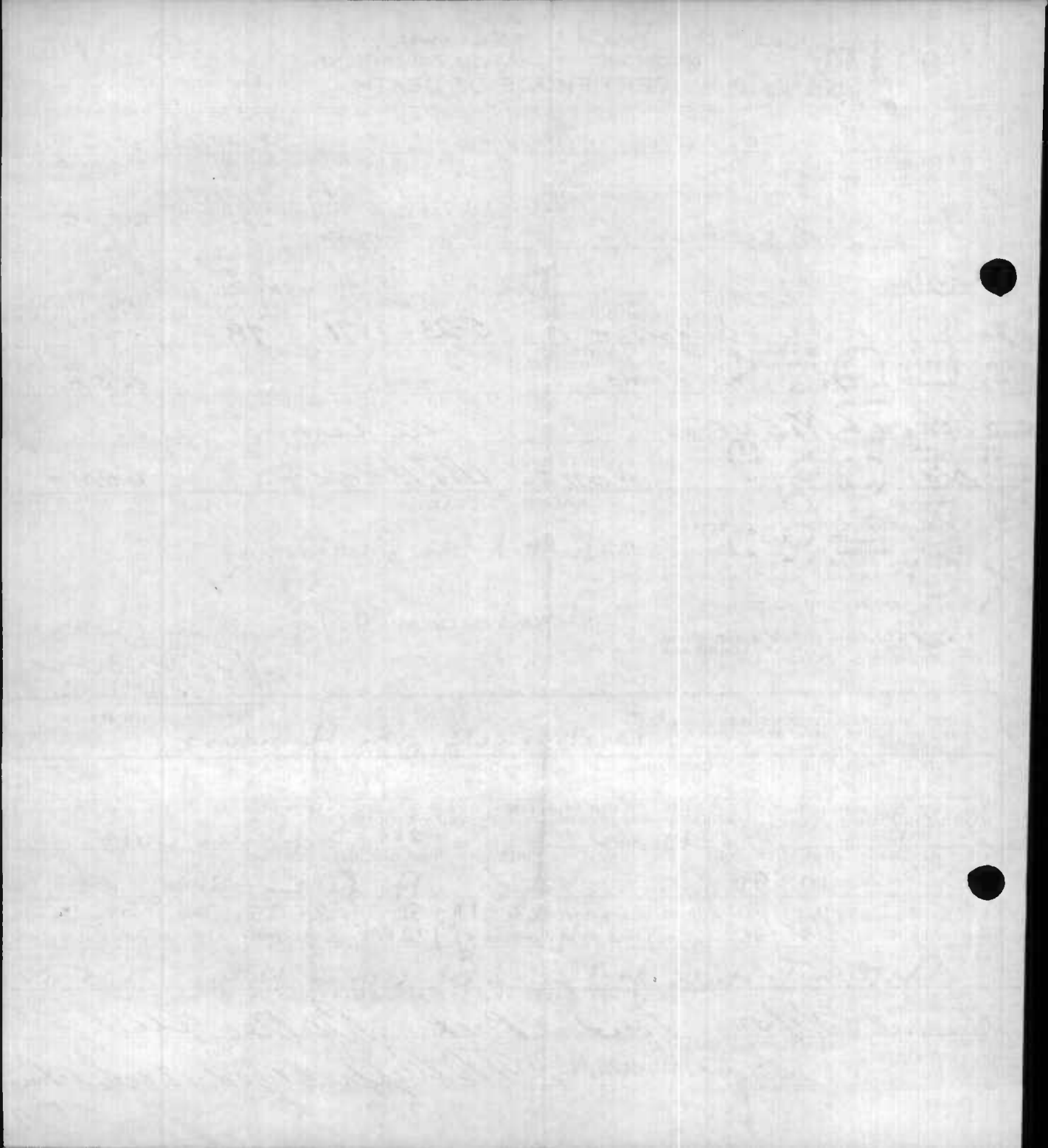
William M. ...

25. FUNERAL DIRECTOR

G. W. Wippert & Son - 1200 E. ...

ADDRESS

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1777
Registered No.

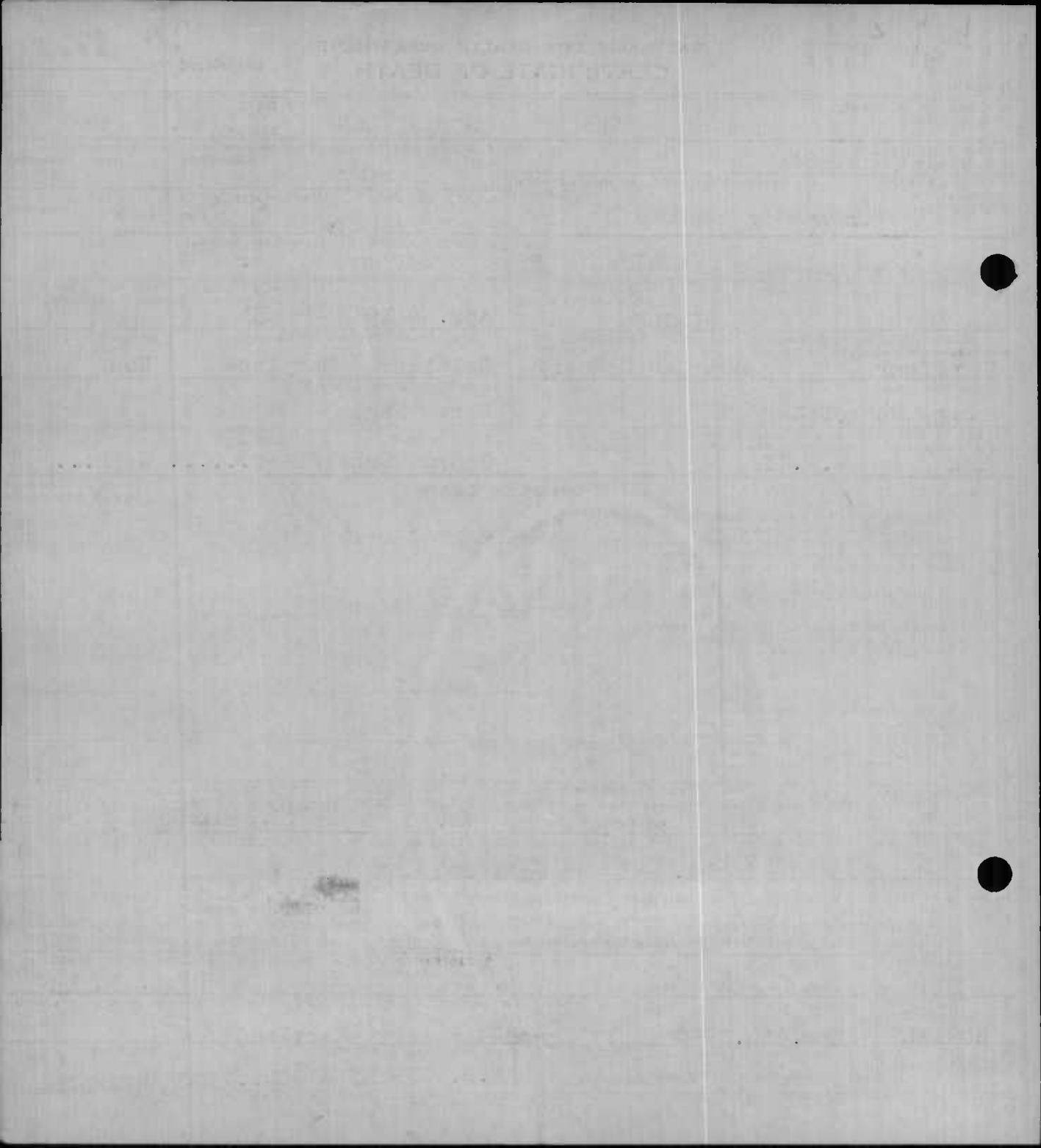
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Leo Carl SCHAEFFLER		2. DATE OF DEATH Feb. 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-18	
6. LENGTH OF STAY IN BALTIMORE LIFE Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 3627 Hayward Ave.	
7. SEX M	8. COLOR OR RACE W	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	10. DATE OF BIRTH Apr. 4 1918
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		12. AGE (In years last birthday) 31 If Under 1 Year: Months: Days: Hours: Min.	
13. FATHER'S NAME George Schaeffler		14. BIRTHPLACE (State or foreign country) Baltimore Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) W.W.II		16. CITIZEN OF WHAT COUNTRY? USA	
17. SOCIAL SECURITY NO.		18. MOTHER'S MAIDEN NAME Mary Fagan	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) W.W.II		20. INFORMANT ADDRESS George Schaeffler..... Same...	

CAUSE OF DEATH

18. E8164 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Sub arachnoid Hemorrhage DUE TO (B) Chest crushed DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Patapsco River Bridge, Wash. Rt. #1, Howard Co., Elkridge, Md. Blvd.	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Feb. 28, 1950 2:25 PM		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Auto into taxi	
22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE H. J. McClafferty		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED Feb. 28, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Mar. 4th. 1950		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery Maryland	
24D. LOCATION (City, town, or county) (State) MD		25. FUNERAL DIRECTOR F.B. WIPPERT & SON..1300 EUTAW PL		ADDRESS	



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1778**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE THOMAS		2. DATE OF DEATH February 25, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 1403 Ten Pin Alley		5. LENGTH OF stay in Baltimore Yrs. 0 Mos. 0 Days 0	
6. COLOR or RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 5, 1893	9. AGE (In years last birthday) 56 If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Eleanor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give year or dates of service) (1)		16. SOCIAL SECURITY NO.	
17. INFORMANT Margaret T. Thomas		ADDRESS 1403 Ten pin alley	

18. 1921-1-1 002X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH (over)
CAUSE OF DEATH (A) Arteriosclerotic cardiovascular disease DUE TO		
(B) Pulmonary tuberculosis DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE Earl L. Rye	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....	23C. DATE SIGNED Feb. 25, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-1-1950	24C. NAME OF CEMETERY OR CREMATORY Balto National Cem Balto
24D. LOCATION (City, town, or county) (State) MD	25. FUNERAL DIRECTOR Rayner Sanders	ADDRESS 1412 E. Preston St

Correction - Cause of death

See Document File 50-1778

4-19-50

Es

160
50 1779BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1779
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Grace Kisher Roper.

2. DATE
OF
DEATH

2-28-50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Dr's Hospital*B. FULL NAME OF
HOSPITAL OR
INSTITUTION*Doctors Hospital*4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

*Md.*C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)*Baltimore**20-06*

D. STREET ADDRESS (If rural, give location)

2825 Sunset Drive

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*FEMALE**White**MARRIED*10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Housewife*10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Charlestown West. Va.*12. CITIZEN OF
WHAT COUNTRY*U.S.*

13. FATHER'S NAME

Franklin Kisher

14. MOTHER'S MAIDEN NAME

*AMY VIRGINIA HARDY*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

*ARBUS R. ARNOLDI 2825 Sunset Drive*18. *443X*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *Pneumonia*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Hypertension*

DUE TO

(C) *vascular disease*

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 23, 1950* to *Feb 28, 1950* that I last saw the
deceased alive on *Feb 28, 1950*, and that death occurred at *11:30 PM* from the causes and on the date stated above.

23A. SIGNATURE

Albert H. Katz

M. D.

23B. ADDRESS

2675 WICKENS AVE

23C. DATE SIGNED

*MARCH 1/50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

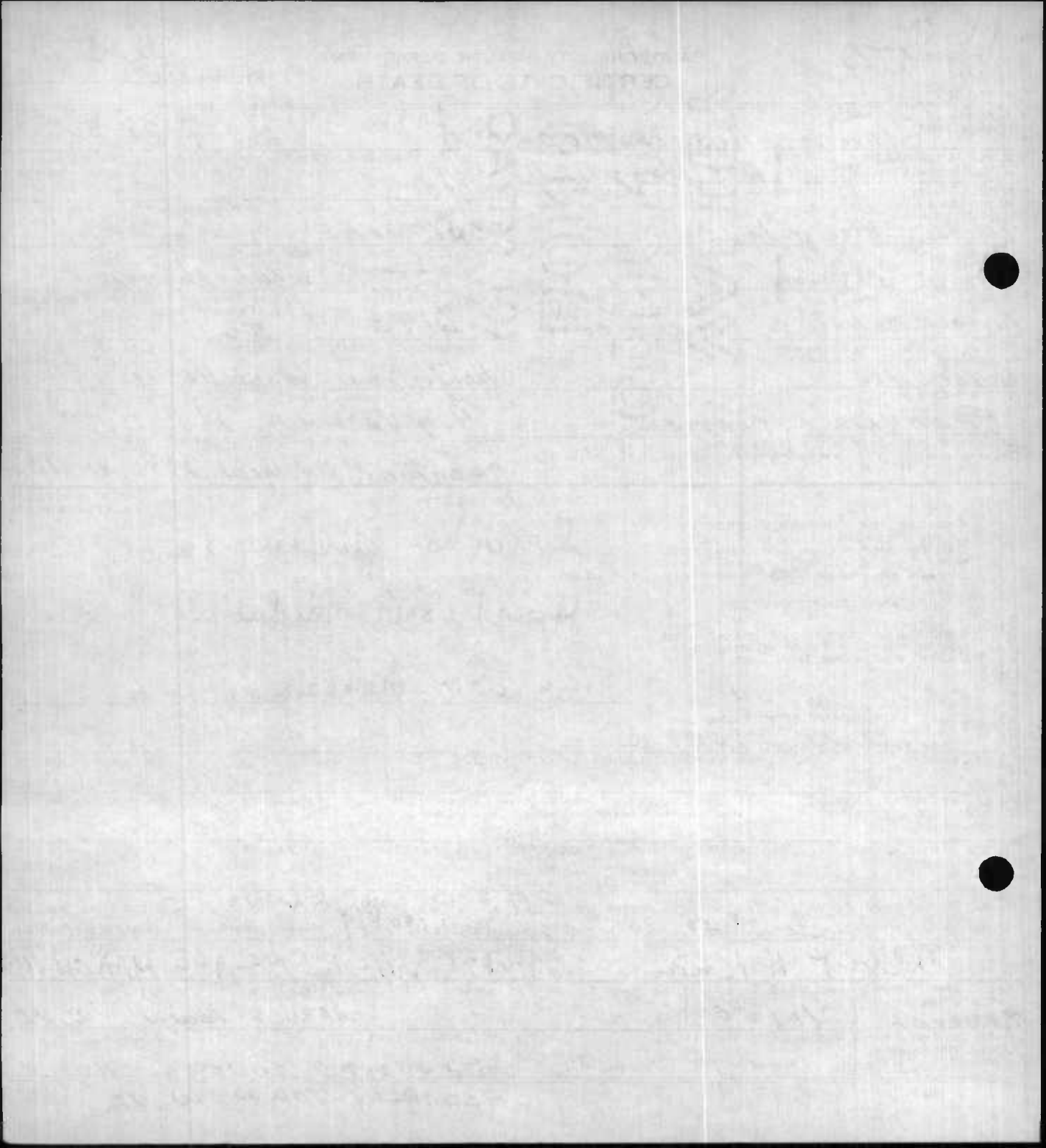
*REMOVAL**3/1/50**CHARLES TOWN W. VA.*DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*MAR 7 1950**William Williams, Jr.**SMITH & SNYDER FUNERAL HOME*



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1780
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ISABEL

WALLACE

2. DATE
OF
DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore City

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1504 E. Lombard Street

Length of stay in Baltimore

30 Yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 19, 1871

9. AGE (In years
last birthday)

78 71

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Back River Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Chambers

14. MOTHER'S MAIDEN NAME

Julia Chambers

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Esther Lewis 1424 N. Fulton Ave

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Arteriosclerotic Cardio-

DUE TO

Vascular Disease

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Ins. & Inquiry thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

H. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER.....☐
ASSISTANT MEDICAL EXAMINER.....☒
M.D. MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

2-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/31/1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary Cem.

24D. LOCATION (City, town, or county)

Brooklyn A.A.Co.Md

(State)

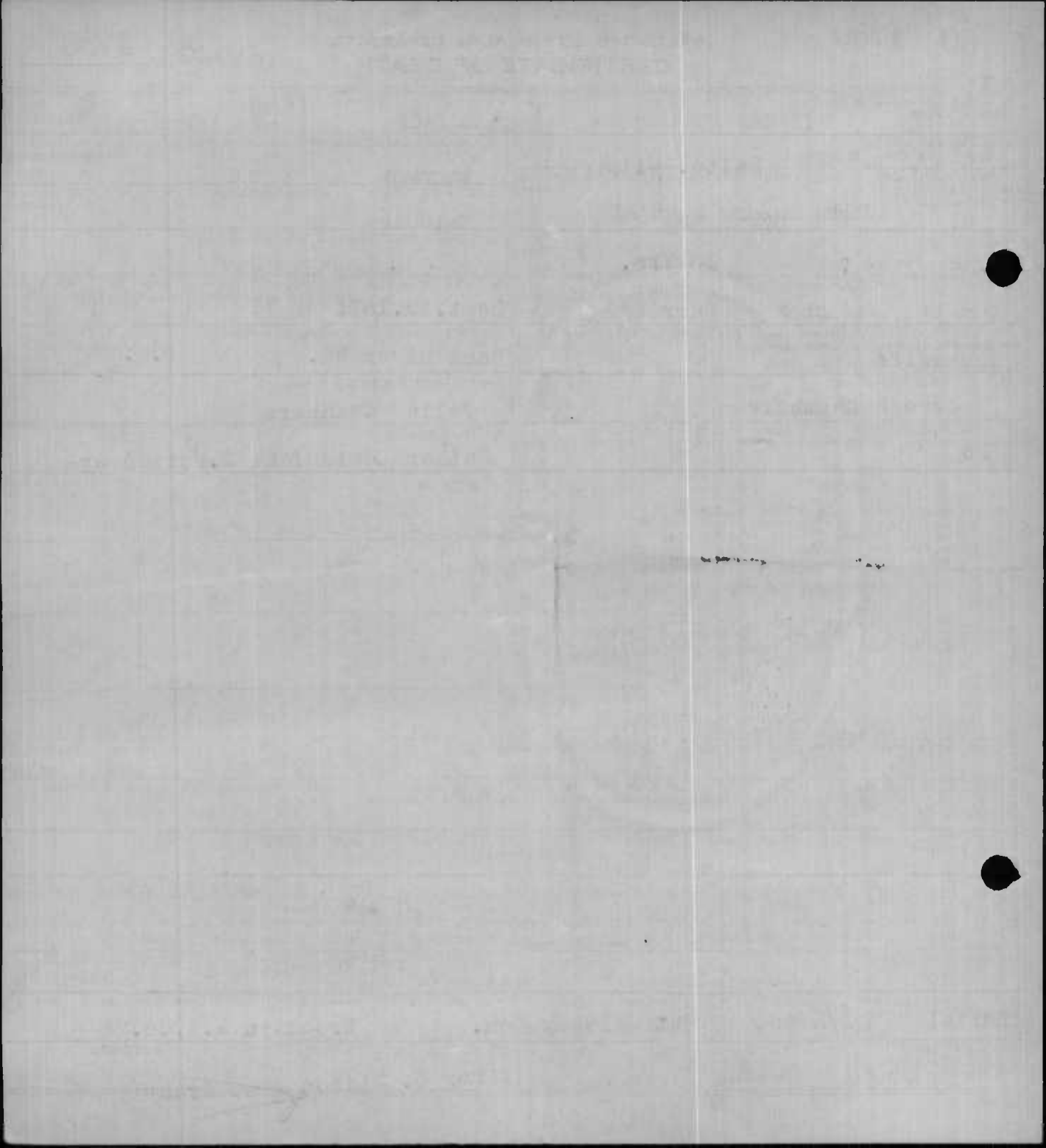
DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Elroy O. Wilson 1000 Brantly Ave



100
50 1781BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1781

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JOHN POPE

2. DATE
OF
DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY,

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6914 Fait Avenue

Length of stay in Baltimore

40

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Retired LABORER Crosse & Blackwell

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

May. 15-1884

9. AGE (In years last birthday)

65

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Romaniania

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

14. MOTHER'S MAIDEN NAME

Unknown

17. INFORMANT

ADDRESS

Elis Pope Sr. 6914 Fait Ave.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY

LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. S. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒
ASSISTANT MEDICAL EXAMINER.....☐
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

Feb. 27, 1950

24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

3/1/50

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart. Berman Hill Rd. Md.

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

MAR 1 1950

William H. Williams, Jr.

25. FUNERAL DIRECTOR

John J. Connelly

ADDRESS

Essex, Md.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	

356
50 1782Baltimore
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1782

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Colonel Louis Bottomer		2. DATE OF DEATH Feb 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE md. B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION Church Home & Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18 12-06	
6. LENGTH OF STAY IN BALTIMORE 59		D. STREET ADDRESS (If rural, give location) 2808 Maryland Ave.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 4, 1890
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Buyer		10B. KIND OF BUSINESS OR INDUSTRY Lamps Etc	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Francis Bottomer		14. MOTHER'S MAIDEN NAME Claire Spicer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. 212-05-6433	
17. INFORMANT Connolly		ADDRESS Mr. Lee 230 Murdock Rd.	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 151X	CAUSE OF DEATH (A) Carcinomatosis DUE TO (B) Carcinoma of Stomach DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

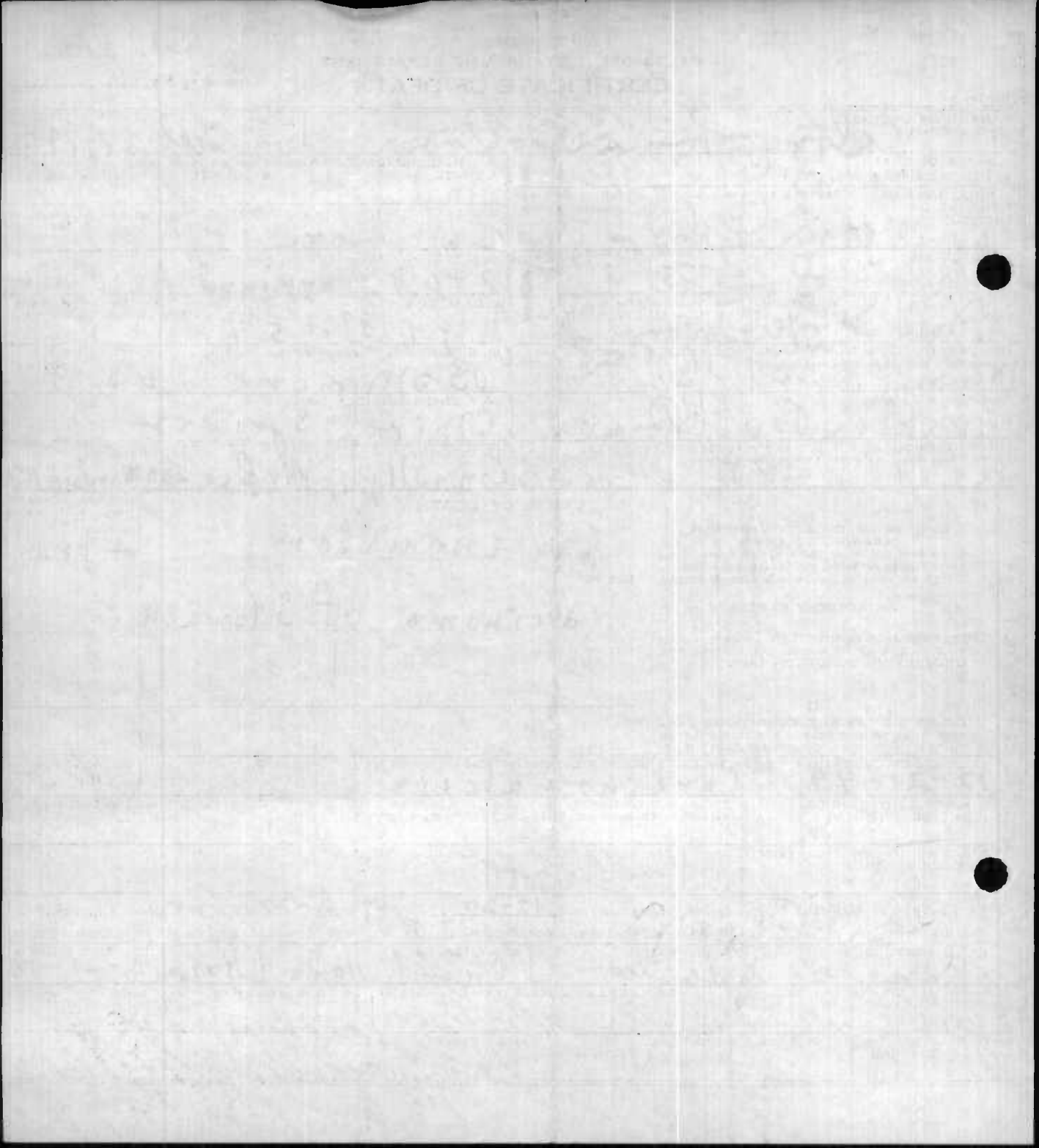
19A. DATE OF OPERATION 12-21-49	19B. MAJOR FINDINGS OF OPERATION Carcinomatosis	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **12-20**, 19**49** to **2-27**, 19**50** that I last saw the deceased alive on **2-27**, 19**50**, and that death occurred at **3 P.** m., from the causes and on the date stated above.

23A. SIGNATURE Ronald S. Hester	23B. ADDRESS Church Home & Hosp.	23C. DATE SIGNED 2-27-50
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24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE MAR 2 1950	24C. NAME OF CEMETERY OR CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Baeto. Md
--	--------------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1950	REGISTRAR'S SIGNATURE William H. Jenkins	25. FUNERAL DIRECTOR Henry H. Jenkins	ADDRESS Sondo 495 York Rd
---	--	---	-------------------------------------



50 1783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1783

Registered No.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SISTER M. MICHAEL SCHIPPER

2. DATE
OF
DEATH

28 Feb 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

MT. ST. AGNES - MT. WASHINGTON

C. Length of stay in Baltimore

55

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

Smith Ave., Mt. Washington

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

7/12/75

9. AGE (In years last birthday)

74

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Sister of Mercy

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Bernard J. Schipper

14. MOTHER'S MAIDEN NAME

Not obtainable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Convent Records Mt. Washington

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ARTERIOSCLEROTIC-HEART DISEASE
DUE TO DISEASE
CARDIAC FAILURE
DUE TO SENILITY5 yrs.
1 yr.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22A. TIME (Month) (Day) (Year) (Hour) OF INJURY

22B. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22C. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1950 to Feb 28, 1950 that I last saw the deceased alive on Feb 5, 1950 and that death occurred at 5 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Mount St. Agnes

24D. LOCATION (City, town, or county)

Mt. Washington

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

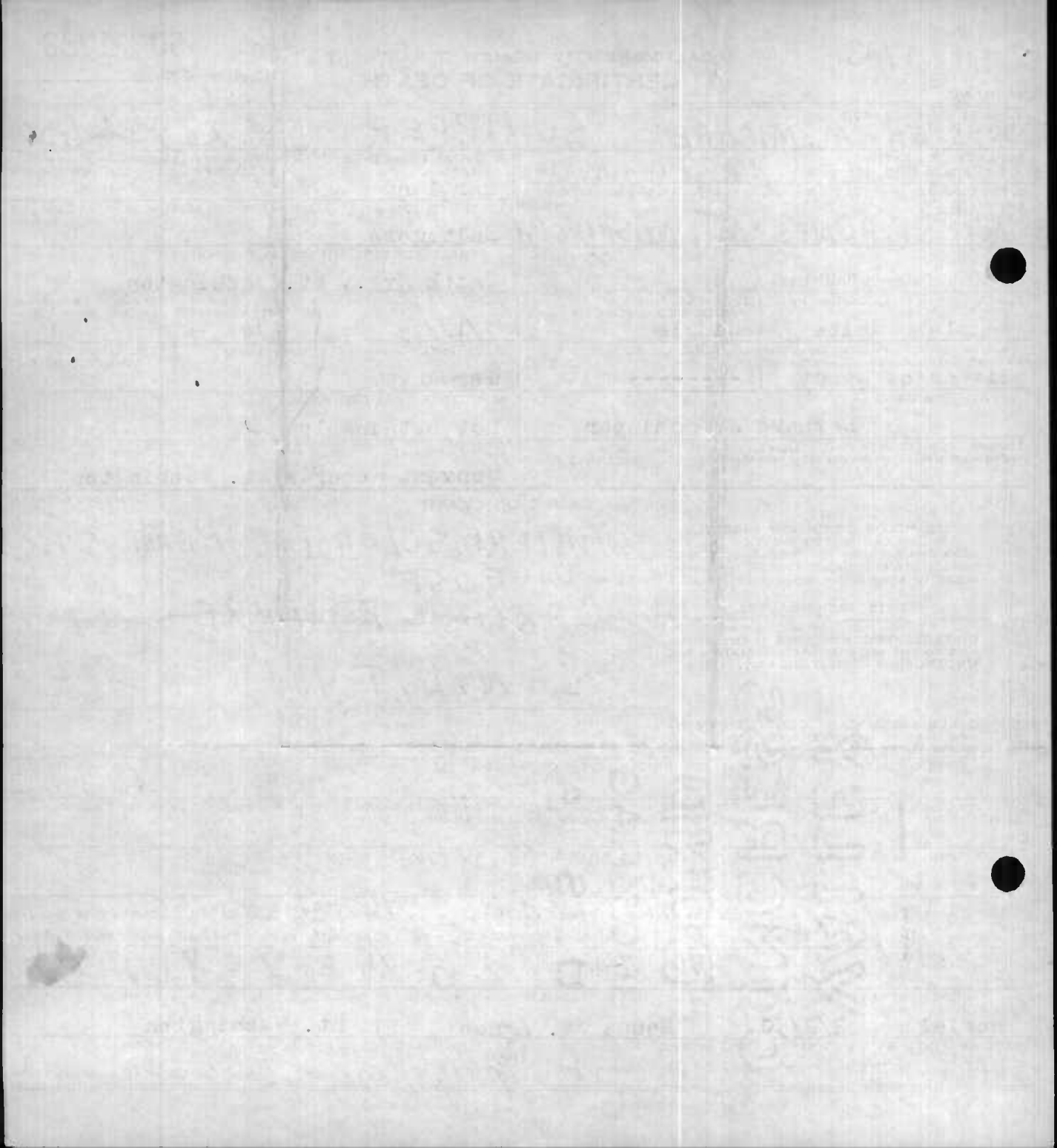
25. FUNERAL DIRECTOR

ADDRESS

MART 1950

Wm. J. Williams, Jr.

W. W. Meeks and Son 205 N. Calvert St.



F-236 1784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1784
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DANIEL FOSTER		2. DATE OF DEATH 2/25/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 533 W. See St		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 22-02	
Length of stay in Baltimore Life Yrs. - Mos. Days		D. STREET ADDRESS (If rural, give location) 533 W. See St	
5. SEX male	6. COLOR OR RACE Col	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1896
10A. USUAL OCCUPATION (Give kind of work done during most of work log life, even if retired) Carpenter		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 54
13. FATHER'S NAME Daniel Foster		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? +	
16. SOCIAL SECURITY NO.		17. INFORMANT William Foster ADDRESS 1108 W. See St	

18. 493X, 490X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia DUE TO (A) (Later)	CAUSE OF DEATH Pneumonia (Later)	INTERVAL BETWEEN ONSET AND DEATH 3 wks (over)
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 2/4 19 50 to 2/25 , 19 50 that I last saw the deceased alive on 2/25 , 19 50 , and that death occurred at 5:00 p.m., from the causes and on the date stated above.				
23A. SIGNATURE Daniel Traub M. D.	23B. ADDRESS 122 W See St	23C. DATE SIGNED 2/25/50		

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 2/1/50	24C. NAME OF CEMETERY OR CREMATORY Mt Auburn	24D. LOCATION (City, town, or county) (State) Baltimore Md
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE William Foster	25. FUNERAL DIRECTOR Sarah L Brown ADDRESS 108 W See St	

MAR 1 1950

308197 8 6

108

MEDICAL CERTIFICATION

See Document File 50-1784

4-19-50

Es

A-536
50 1785BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

X 50 1785

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JOHN B. ANDERSON.

2. DATE
OF
DEATH

2/28/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland ✓

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Church Home & Hospital.

Length of stay in Baltimore

Aut. State
HospitalYrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Nurse & Housekeeper

JOB, KIND OF BUSINESS OR
INDUSTRY

Nursing

13. FATHER'S NAME

John Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

40 Union Street

8. DATE OF BIRTH

11/19/1874

9. AGE (In years
last birthday)

75

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

Mary Gray

17. INFORMANT

ADDRESS

This lady, Sister Church Home & Hospital

18. 434.3

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

DUE TO

(A) Heart failure.

4 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B) One brot tuberculosis.

2 mos

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

(C) Tuberculosis -
pulmonary, inactive

4 years

(over)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to 2/28/1950, that I last saw the
deceased alive on 2/28/1950, and that death occurred at 4:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

James G. Means

23B. ADDRESS

M. D.

Church Home & Hospital

23C. DATE SIGNED

2/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

3/1/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Holly Cem.

24D. LOCATION (City, town, or county) (State)

Mt. Holly, N. J.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William J. Tickner & Sons

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.

MAY 1 1950

VS 150

1500001787

83B

Was the action at
time of death and
was it pulmonary or
another type?

If not action, was cerebral
thrombosis or heart disease,
in your opinion, the
underlying cause of death?

Heart failure = cause of death

4-19-50

ES

C-155
50 1786BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1786
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Hayes Chapman

2. DATE
OF
DEATH

28 Feb 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4208 OAKFORD AVE.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md. 4208 Oakford Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 15-Md. 28-01

D. STREET ADDRESS (If rural, give location)

4208 Oakford

Length of stay in Baltimore

yr.

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

22 June 1880

9. AGE (In years,
last birthday)

69

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Banking & Manager

10B. KIND OF BUSINESS OR
INDUSTRY

University Club

13. FATHER'S NAME

Robert B. Chapman

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

USA

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs William Chapman 4208 Oakford
Baltimore

18. 491X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Bronchopneumonia

8 days

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 28 Feb, 1950, to 28 Feb, 1950, that I last saw the
deceased alive on 28 Feb, 1950, and that death occurred at 6:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Paul X Royce

23B. ADDRESS

M. D.

Pikesville 8 Md

23C. DATE SIGNED

28 Feb 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Cremation

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Green Mount Crem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER & SONS

Balto., Md.

STATE OF CALIFORNIA

DEPARTMENT OF PUBLIC SAFETY

OFFICE OF THE ATTORNEY GENERAL

OFFICE OF THE REGISTER OF VOTERS

OFFICE OF THE CLERK OF THE SUPERIOR COURT

OFFICE OF THE CLERK OF THE DISTRICT COURT

OFFICE OF THE CLERK OF THE COUNTY COURT

OFFICE OF THE CLERK OF THE JUDICIAL BRANCH

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OFFICE OF THE CLERK OF THE JUDICIAL BRANCH

S-561

50

1787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1787

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SADIE E. SUMMERVILLE

2. DATE
OF
DEATH

2-27-50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

612 N. CAROLINE ST.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
a. STATE

Md

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE 5-01

d. STREET ADDRESS (If rural, give location)

612 N. CAROLINE ST

Length of stay in Baltimore

40 YRS.

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

C.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

12-11-1883

9. AGE (In years,
last birthday)

66

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10a. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

PETER A. FISHER

14. MOTHER'S MAIDEN NAME

ELIZA A. DENNARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
MINNIE PURNELL 1534 E. MASON ST.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Apoplexy

DUE TO

14 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Hypertensive C.V.D.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21b. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 2-2, 1950, to 2-27, 1950, that I last saw the
deceased alive on 2-26, 1950, and that death occurred at 8:24 m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

M. D.

1113 N. Caroline St.

2-28-50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State)

BURIAL

3-2-50

ARBOTUS MEN. PK.

ARBOTUS, Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

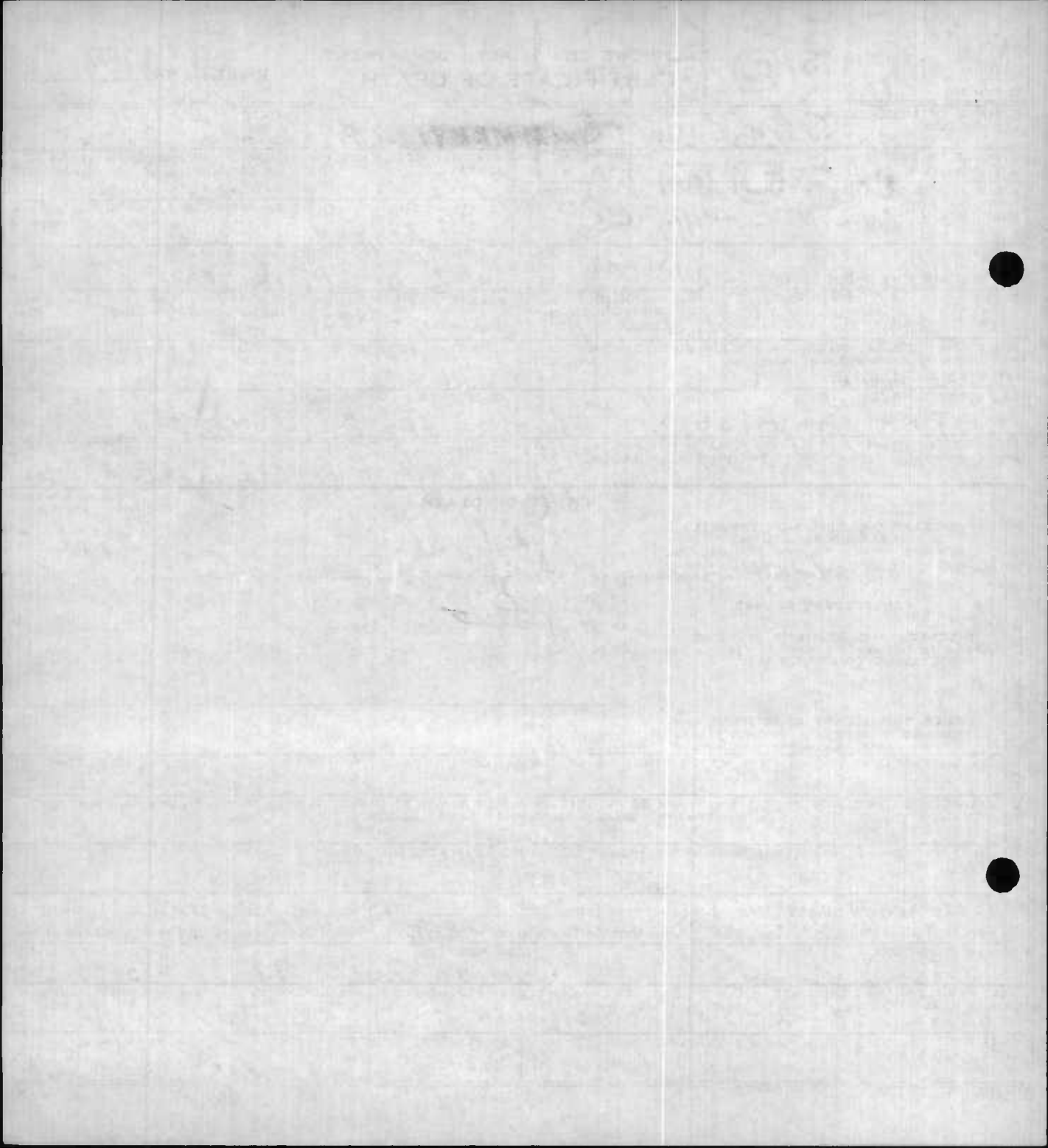
MAR 1 1950

VS 150

Joseph S. Locks 1304 N. Central Ave

VS 150

93D



W-252
50 1788BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1788

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Robert WASHINGTON		Feb. 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital		A. STATE Maryland B. COUNTY	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		D. STREET ADDRESS (If rural, give location) 920 Sarah Ann St.	
5. SEX M		6. COLOR OR RACE C	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married (Sep.)		8. DATE OF BIRTH Oct. 18, 1904	
9. AGE (In years last birthday) 45		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) Glocester Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Washington		14. MOTHER'S MAIDEN NAME Laura Jefferson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Homerzella Good		ADDRESS 1025 Sarah Ann St.	

18. 4/20/1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)(A) Coransary Artery Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

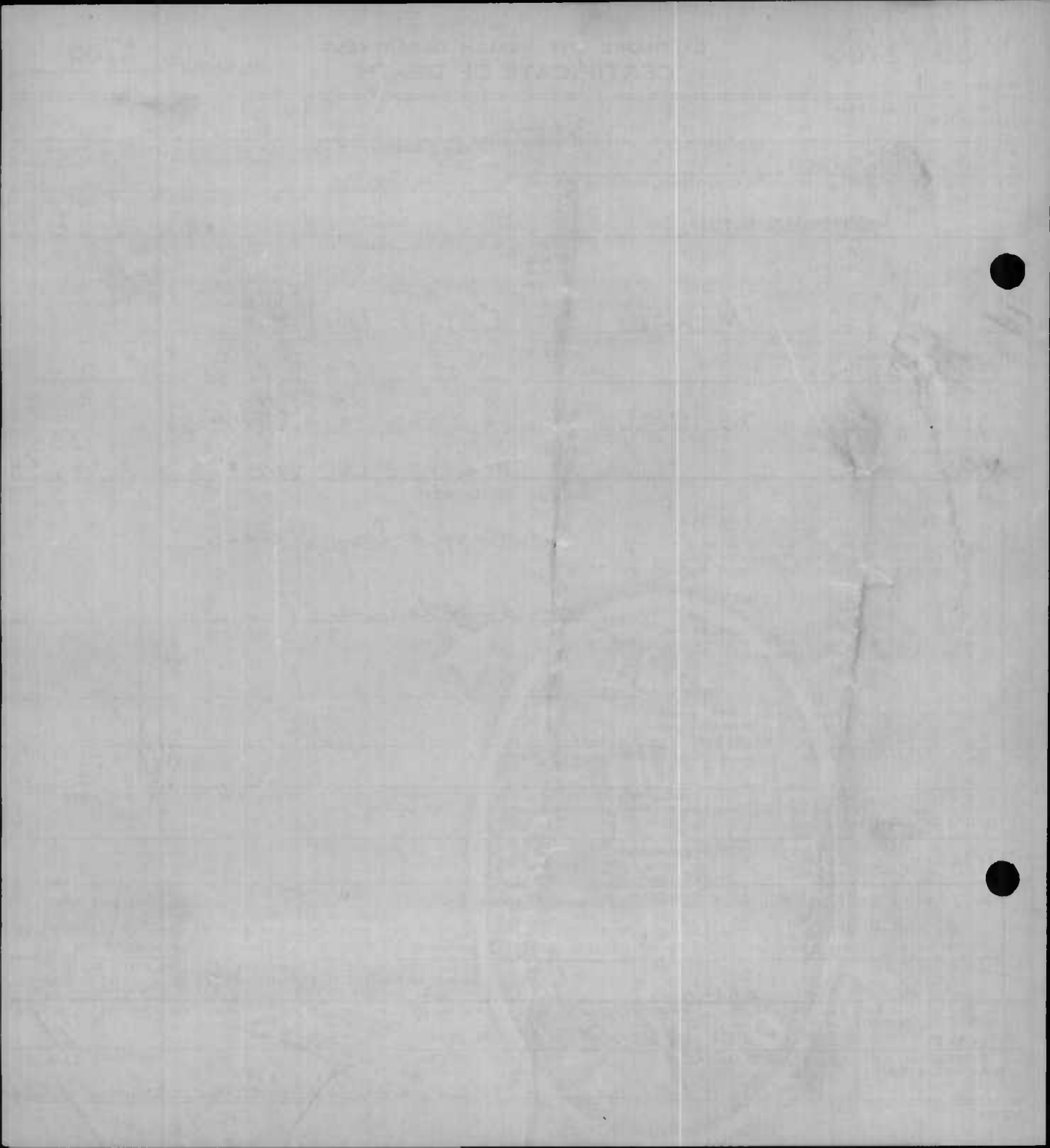
INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE W. J. Mc Clafferty		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED Feb. 27, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-3-50		24C. NAME OF CEMETERY OR CREMATORY Balt. National	
24D. LOCATION (City, town, or county) Balt.		24E. DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1950		24F. REGISTRAR'S SIGNATURE Washington Williams	
24G. FUNERAL DIRECTOR Mrs. Katie R. Williams		24H. ADDRESS 322 N		24I. SIGNATURE Schwartz	



N-400

50 1789

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1789
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Nathaniel Noel

2. DATE
OF
DEATH

Feb. 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1318 N. Stockton St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

15-01

D. STREET ADDRESS (If rural, give location)

1318 N. Stockton St.

Length of stay in Baltimore

Yrs.
Mos.
Days

SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

Male

Col.

Widow

4-10-1882

67

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

Laborer

Middlesex Co., Pa.

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

No

Florence Douglas N. Calhoun St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Artery Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☐23C. DATE SIGNED
26 Feb 5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

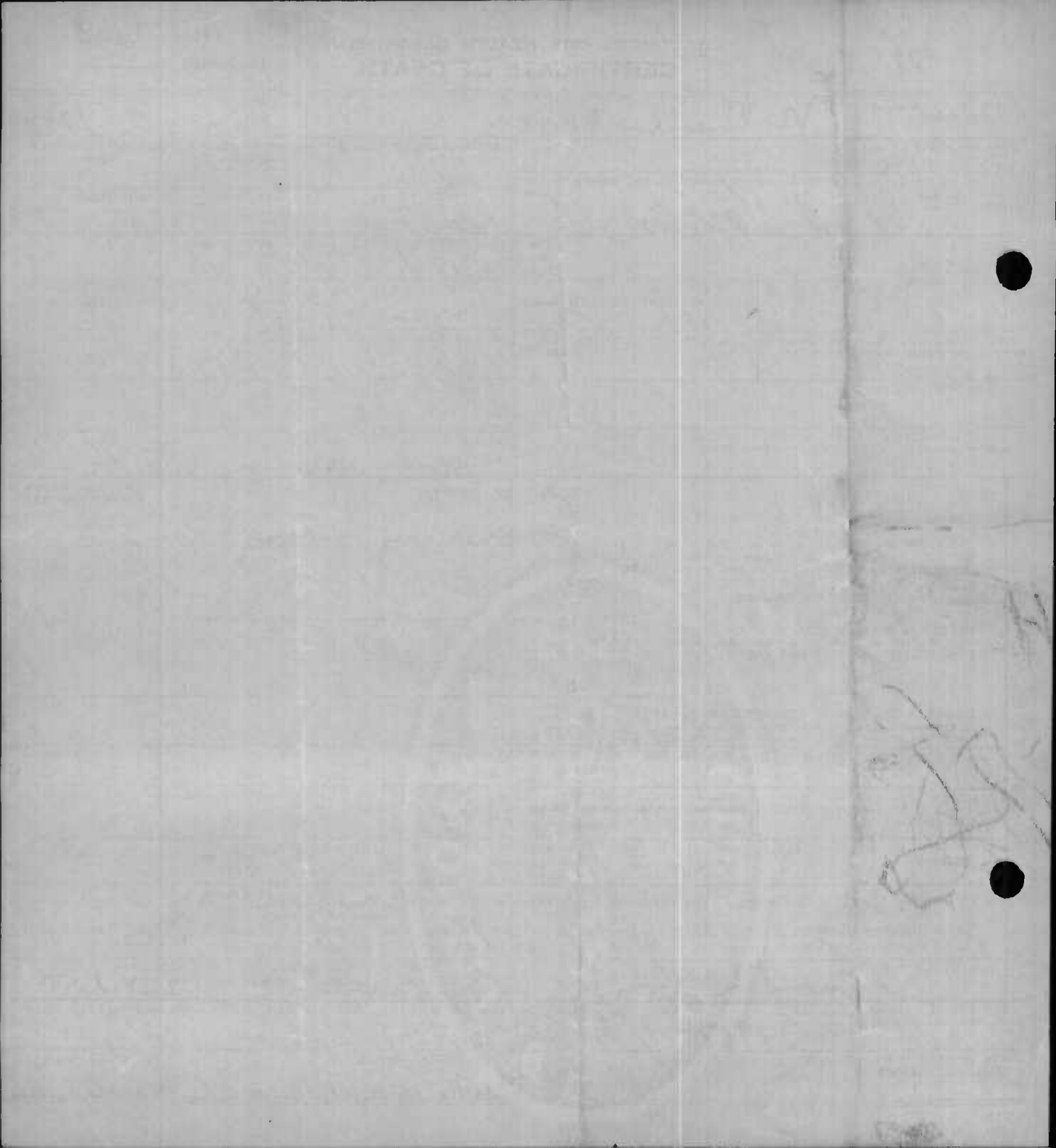
ADDRESS

MAR 1 1950

MAR 1 1950

MAR 1 1950

MAR 1 1950



D-120
50 1790BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1790

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Martha J. Davis.

2. DATE
OF
DEATH

Feb. 27, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

1043 W. Lexington St.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1043 W. Lexington St.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Martha Davis.

1043 W. Lexington St.

18. 330X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 31, 1950, to Feb 27, 1950; that I last saw the deceased alive on Feb 27, 1950, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

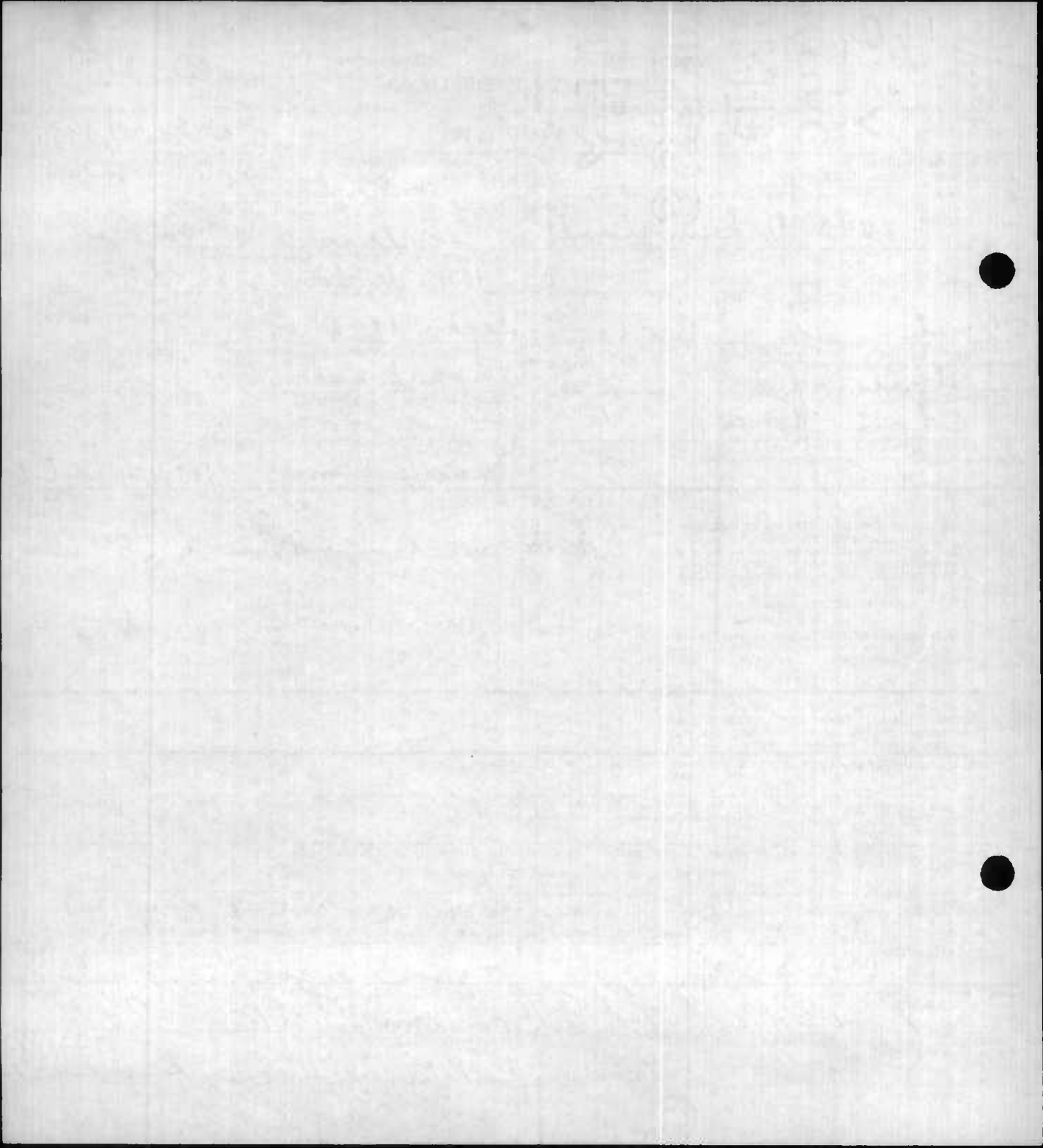
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



M-460
50 1791BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1791
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Eagar Miller

2. DATE
OF
DEATH

2-26-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Balto.

D. STREET ADDRESS (If rural, give location)

414 Eison Street

5. SEX

male

6. COLOR OR RACE

negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 5, 1899

9. AGE (In years;
last birthday)

50

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Westmoreland Co. Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David Miller

14. MOTHER'S MAIDEN NAME

Sarah Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Lottie Tucker 1817 Edmondson Ave

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Congestive Heart Failure

24 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

Arteriosclerotic Ht Disease

years

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from 2-25, 1950 to 2-26, 1950 that I last saw the
deceased alive on 2-26, 1950, and that death occurred at 7:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

William J. Mulvaney

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

2-26-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3-3-1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (city, town, or county)

Balto.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Kate R. Williams, Schenck St.

2-10-52

2-10-52

University Hospital

1111 11th Street

University Hospital

1111 11th Street

A-620
134704
50 1792

CERTIFICATE CORRECTED 3-1-50

50 1792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

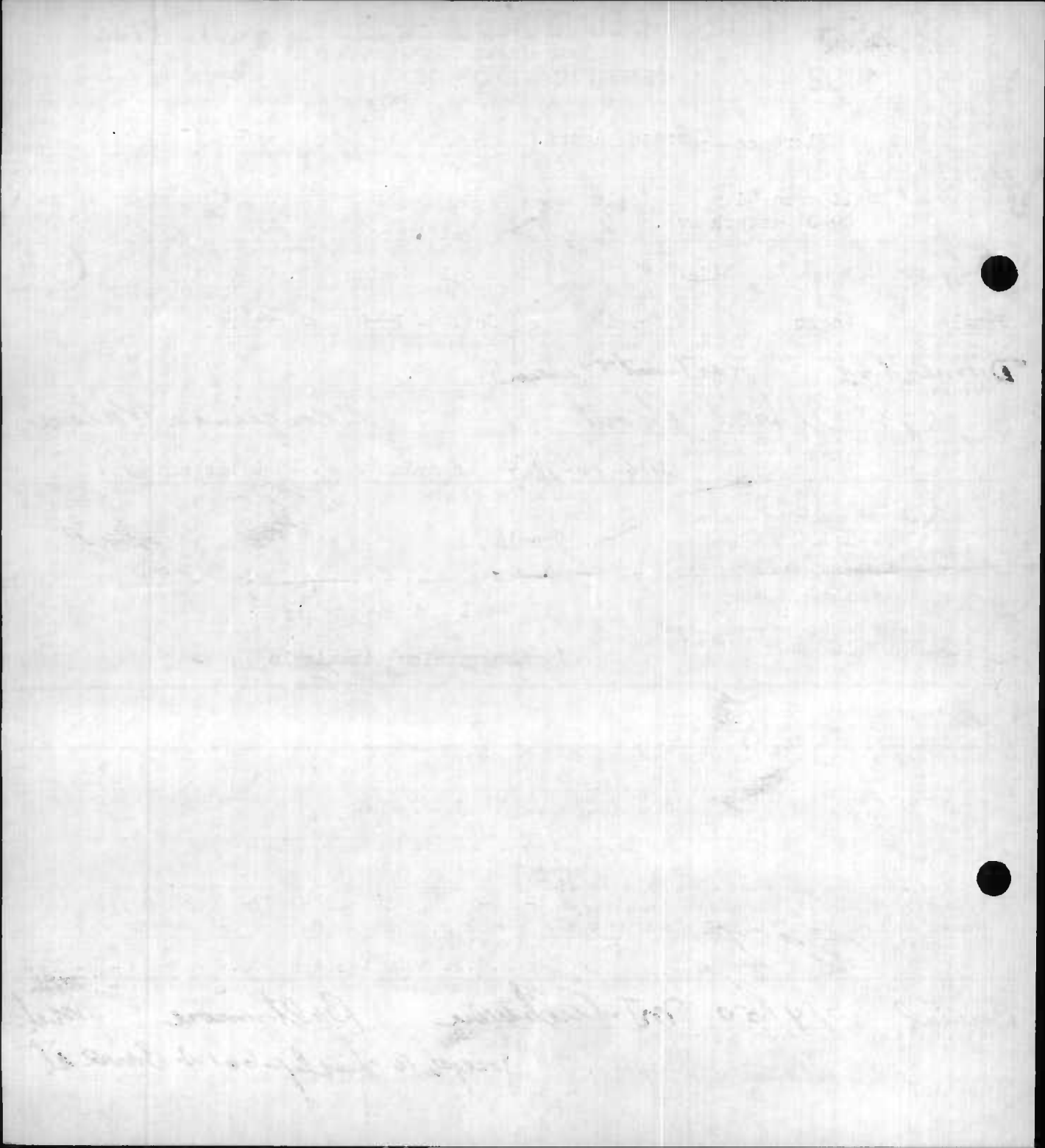
1. NAME OF DECEASED (Type or Print) Florence Theresa Ayers.		2. DATE OF DEATH 27-1950.	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION location) Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-02	
5. LENGTH OF STAY IN BALTIMORE Life		D. STREET ADDRESS (If rural, give location) 631 Eislens ST. Z 30 City	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1882 Oct. 3-1880
9. AGE (In years last birthday) 67-9 Yrs.		10. Under 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Restaurant & Tavern	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME (D) Alfred Prout		14. MOTHER'S MAIDEN NAME (D) Georgianna Palmer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-16-7864	
17. INFORMANT Records B.C.H. 4940 Eastern Ave.		ADDRESS	
18. 037X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Uremia DUE TO Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Bilateral hydronephrosis DUE TO Lymphogranuloma inguinale			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-4 , 1950, to 2-27 , 1950, that I last saw the deceased alive on 2-27 , 1950 and that death occurred at 8.00 PM from the causes and on the date stated above.			
23A. SIGNATURE [Signature]		23B. ADDRESS B.C.H. 4940 Eastern Ave.	
23C. DATE SIGNED 2-28-1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/4/50	
24C. NAME OF CEMETERY OR CREMATORY MT. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore md	
25. FUNERAL DIRECTOR Joseph A. Linley		ADDRESS 661 W. Bane St	

MEDICAL CERTIFICATION

MAR 1 1950

2741717 9 1

44a



K-632

50

1793

BALTIMORE CITY HEALTH DEPARTMENT

50

1793

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Atolia Kordecka

2. DATE
OF
DEATH

Feb. 27-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Balto. City

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

1308. Washington St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md.

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

2-01

D. STREET ADDRESS (If rural, give location)

130 S. Washington Ave

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Female

White

Married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Packer

10B. KIND OF BUSINESS OR
INDUSTRY

Canning Co.

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Stanislaw Poniatowski

14. MOTHER'S MAIDEN NAME

Barbara

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

219-05-0787

17. INFORMANT

ADDRESS,

Jozef Kordecki 130 S. Washington St.

18. 4/20/1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Chronic Myocarditis

2 yrs

(C) DUE TO

Diabetes Mellitus

2 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/12, 1948, to 2/27, 1950, that I last saw the deceased alive on 2/27, 1950, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

Mar. 3-1950

Sacred Heart of Mary

Balto., Co.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

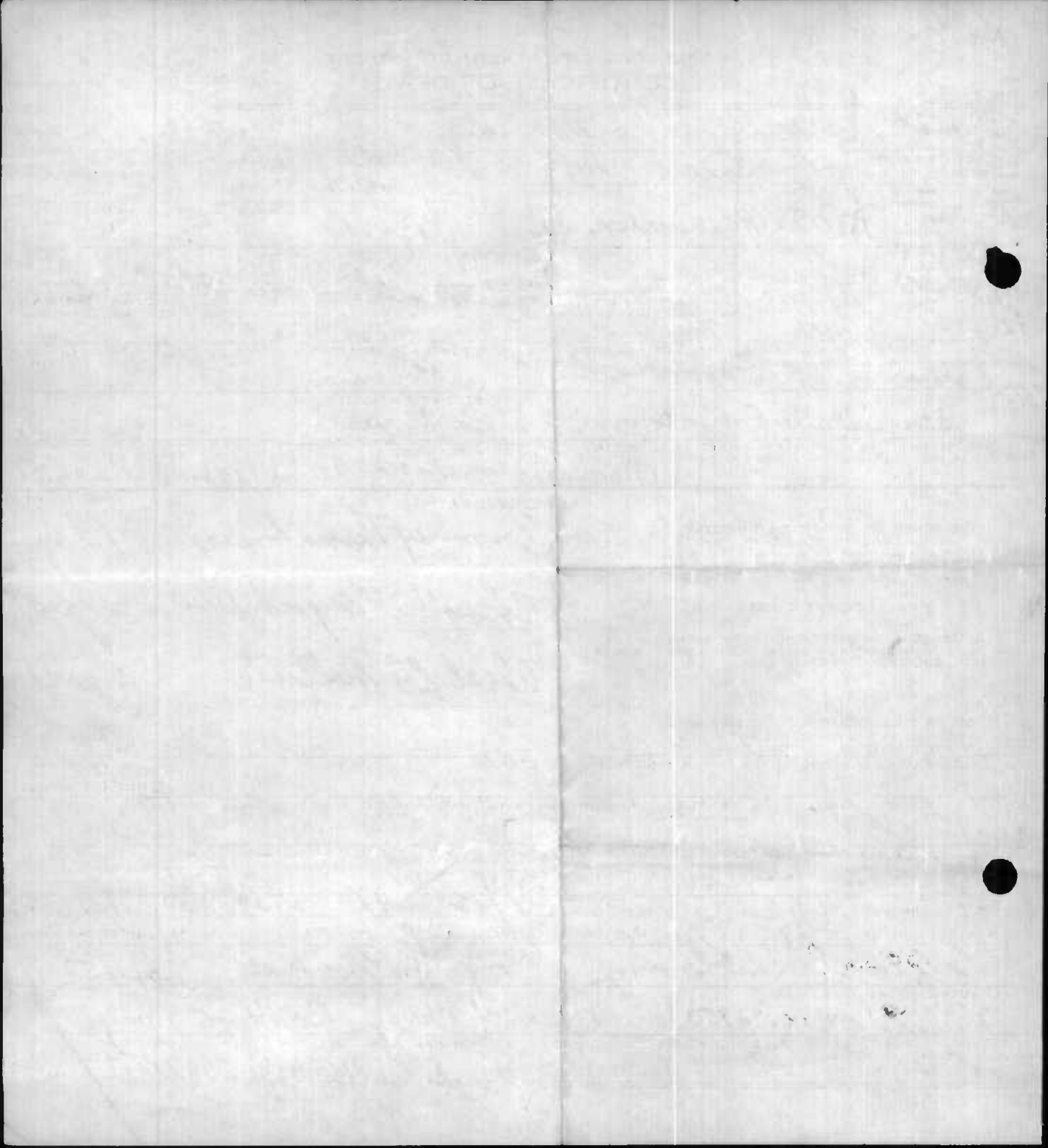
25. FUNERAL DIRECTOR

ADDRESS

MAR 1 1950

William M. Williams

Wm. S. Fialkowski 2007 Eastern Ave



5-512
50 1794

50 1794

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Bert A. Simpson		2. DATE OF DEATH 2/28/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-38	
Length of stay in Baltimore —		D. STREET ADDRESS (If rural, give location) 5701 Chinquapin Parkway	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH April 2, 1971
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 78 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
13. FATHER'S NAME Andrew R. Simpson		12. CITIZEN OF WHAT COUNTRY? American	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or oooowoo) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Katherine Luby	
16. SOCIAL SECURITY NO.		17. INFORMANT Clady's (wife)	
		ADDRESS Same -	

18. 154 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis (A) Carcinoma of rectum - DUE TO (B) Carcinoma of rectum - DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/6/50 , 19 50 , to 2/28 , 19 50 , that I last saw the deceased alive on 4/28/50 , 19 50 , and that death occurred at 11:45 P. m., from the causes and on the date stated above.					
23A. SIGNATURE Charles J. Blazek		23B. ADDRESS Maryland General		23C. DATE SIGNED 2/28/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar 3/1950		24C. NAME OF CEMETERY OR CREMATORY Greenfield	
24D. LOCATION (City, town, or county) (State) Hempstead & I		25. FUNERAL DIRECTOR Harry H. Hancock		ADDRESS 4204 Redwood Ave	
DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1950		REGISTRAR'S SIGNATURE William			

MEDICAL CERTIFICATION

STATE OF NEW YORK
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Occupation		Manner of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1795
Registered No.

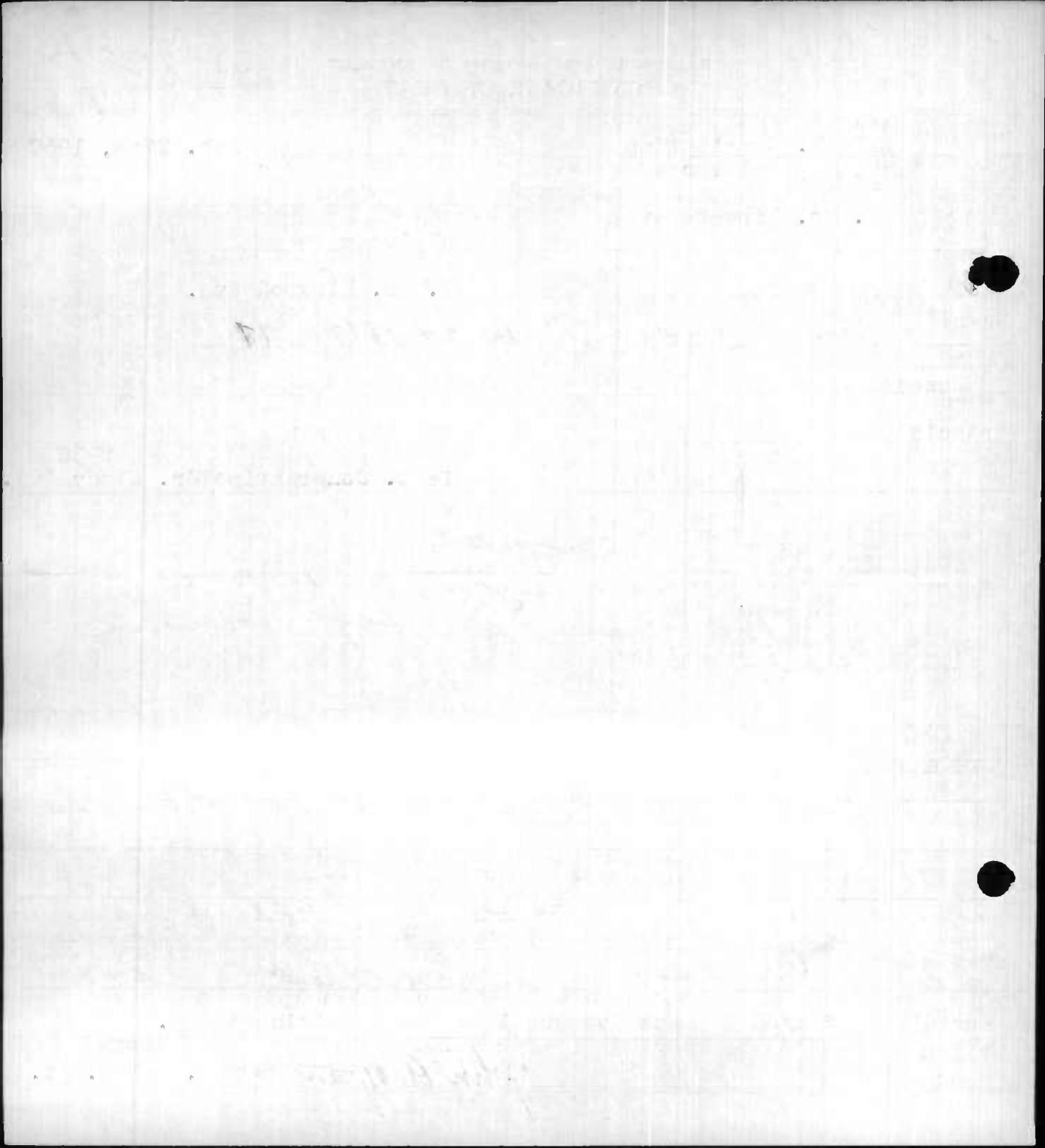
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ella M. Constantine		2. DATE OF DEATH Feb. 27th, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 7. So. Linwood Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 7. So. Linwood Ave.		E. LENGTH OF stay in Baltimore Life	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 24 1872
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Francis Dugan		14. MOTHER'S MAIDEN NAME Mary Ella Egan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charle C. Constantine Jr.		ADDRESS 2936 Elmey Ave.	

18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Primary Cause Disease DUE TO (B) Secondary Premises DUE TO (C) arteriosclerosis - heart	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 20 34 to Feb 27 50 , that I last saw the deceased alive on Feb 27, 1950 , and that death occurred at 8 PM. from the causes and on the date stated above.					
23A. SIGNATURE John A. Moran		23B. ADDRESS 2936 Elmey Ave.		23C. DATE SIGNED 2-28-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/4/50		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
				24D. LOCATION (City, town, or county) (State) Baltimore Md.	

DATE RECEIVED BY LOCAL REGISTRAR AR 1 1950		REGISTRAR'S SIGNATURE John A. Moran		25. FUNERAL DIRECTOR John A. Moran	
				ADDRESS 3000 E. Balto. St.	



R-363
50 1796

50 1796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) LILLIAN MAE RODERT		2. DATE OF DEATH Feb. 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 1819 E. 30th St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE	
c. Length of stay in Baltimore LIFE Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 1819 E. 30th St.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH NOV. 4, 1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years, last birthday) 69 If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HENRY MOORE		14. MOTHER'S MAIDEN NAME SUSAN WALDO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT JOSEPH E. RODERT		ADDRESS 608 N. MILTON	

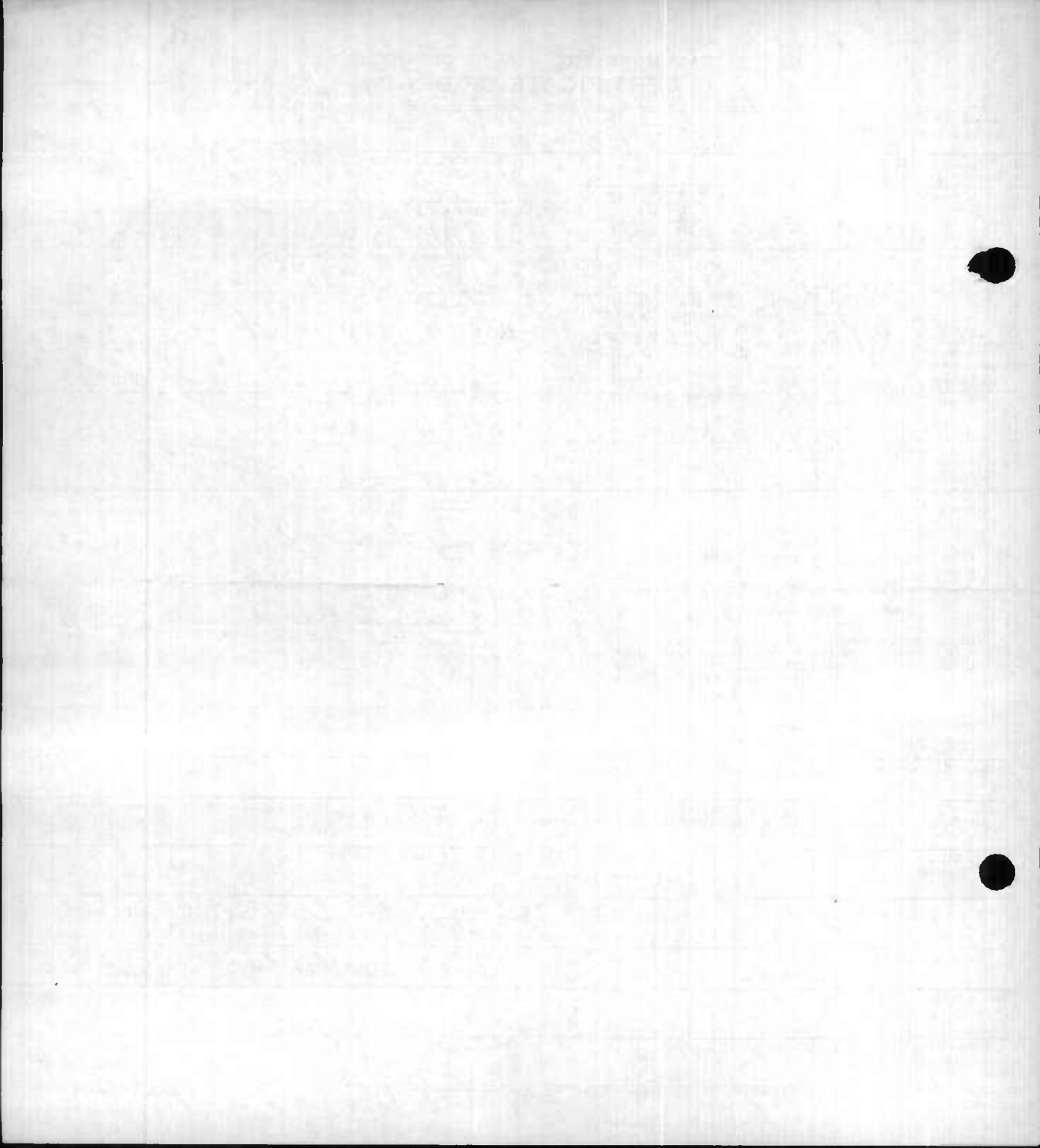
18. 4201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis (A) _____ DUE TO arteriosclerosis (B) Hypertensive cardiovascular and disease with auricular fibrillation DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH 6 wks ?
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **December 7, 1946**, to **Feb. 27, 1950**, that I last saw the deceased alive on **Feb. 27, 1950**, and that death occurred at **11A. m.**, from the causes and on the date stated above.

23A. SIGNATURE E. J. Salner	23B. ADDRESS 6217 Harford Rd	23C. DATE SIGNED 3/1/50
---------------------------------------	--	-----------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Mar. 2	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	24D. LOCATION (City, town, or county) (State) Baltimore Md
DATE RECEIVED BY LOCAL REGISTRAR MAR 1 1950	REGISTRAR'S SIGNATURE John A. Moran	25. FUNERAL DIRECTOR John A. Moran	
		ADDRESS 3000 E. Balto St Balti. 24. Md	



K-656

50 1797

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1797
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE JOSEPH KOERNER

2. DATE
OF
DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 408 N. Port St.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE Maryland B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 6-02D. STREET ADDRESS (If rural, give location)
408 N. Port Street

Length of stay in Baltimore life

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

May 27, 1871

9. AGE (In years
last birthday)

78

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired10B. KIND OF BUSINESS OR INDUSTRY
B & O. R. R.11. BIRTHPLACE (State or foreign country)
Baltimore, Md.12. CITIZEN OF
WHAT COUNTRY?
U.S.

13. FATHER'S NAME

George Koerner

14. MOTHER'S MAIDEN NAME

Anna M. Kuhn

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

George J. Koerner-son-Phila. Rd. White Marsh

18. 470.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Coronary Heart Disease
DUE TO Coronary Sclerosis

(B) Heart Block
DUE TO Myocardial Infarction

(C) Coronary occlusion

17.

1 day

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY
YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3/2/49, to Feb 27-1950, that I last saw the deceased alive on Feb 27, 1950, and that death occurred at 12:45 p.m., from the cause and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

March 2, 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cemetery

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd. Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 1 1950

Schimmunek Funeral Home, Inc.
2601-3-5 E. Madison St.

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 3-1-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 1798 Registered No.

50 1798

M-600

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ida Meyer

2. DATE OF DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2419 E. Madison St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

11-15-72

9. AGE (In years: last birthday)

77

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Czechoslovakia

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Henry Brodt

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

JOHNS HOPKINS HOSPITAL

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Pulmonary edema & shock 5d

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

Acute myocardial infarct "

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension & atherosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2-23, 1950, to 2-27, 1950, that I last saw the deceased alive on 2-27, 1950, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Green Cathers

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

March 2, 1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

24D. LOCATION (City, town, or county)

North Ave. & Rose St. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc.
2601-3-5 E. Madison St.

ADDRESS

MEDICAL CERTIFICATION

STATE OF NEW YORK
CERTIFICATE OF DEATH

Richardson Edmund
1845 June 10
1845 June 10

John L. L. L.

C-550
50 1799BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1799
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Elizabeth Coonan

2. DATE
OF
DEATH

Feb 27-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
(If not in hospital or institution, give street address or
location)

Nursing Home

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR
INDUSTRY

none

13. FATHER'S NAME

Michael Coonan

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

no

(If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

4. USUAL RESIDENCE (Where deceased lived, If institution: residence,
before admission)

A. STATE Md.

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore 11-027

O. STREET ADDRESS (If rural, give location)

121-W-Lafayette

8. DATE OF BIRTH

Oct 4-1-1872

9. AGE (In years,
last birthday)

77 73 yrs

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

14. MOTHER'S MAIDEN NAME

Adele Brennan

17. INFORMANT

E. V. Coonan (Bro) 121 W Lafayette

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary Thrombosis 1 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Hypertension
Myocarditis
Arterio SclerosisGradual
✓

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1948 to Feb 27, 1950, that I last saw the
deceased alive on Feb 27, 1950, and that death occurred at 7 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

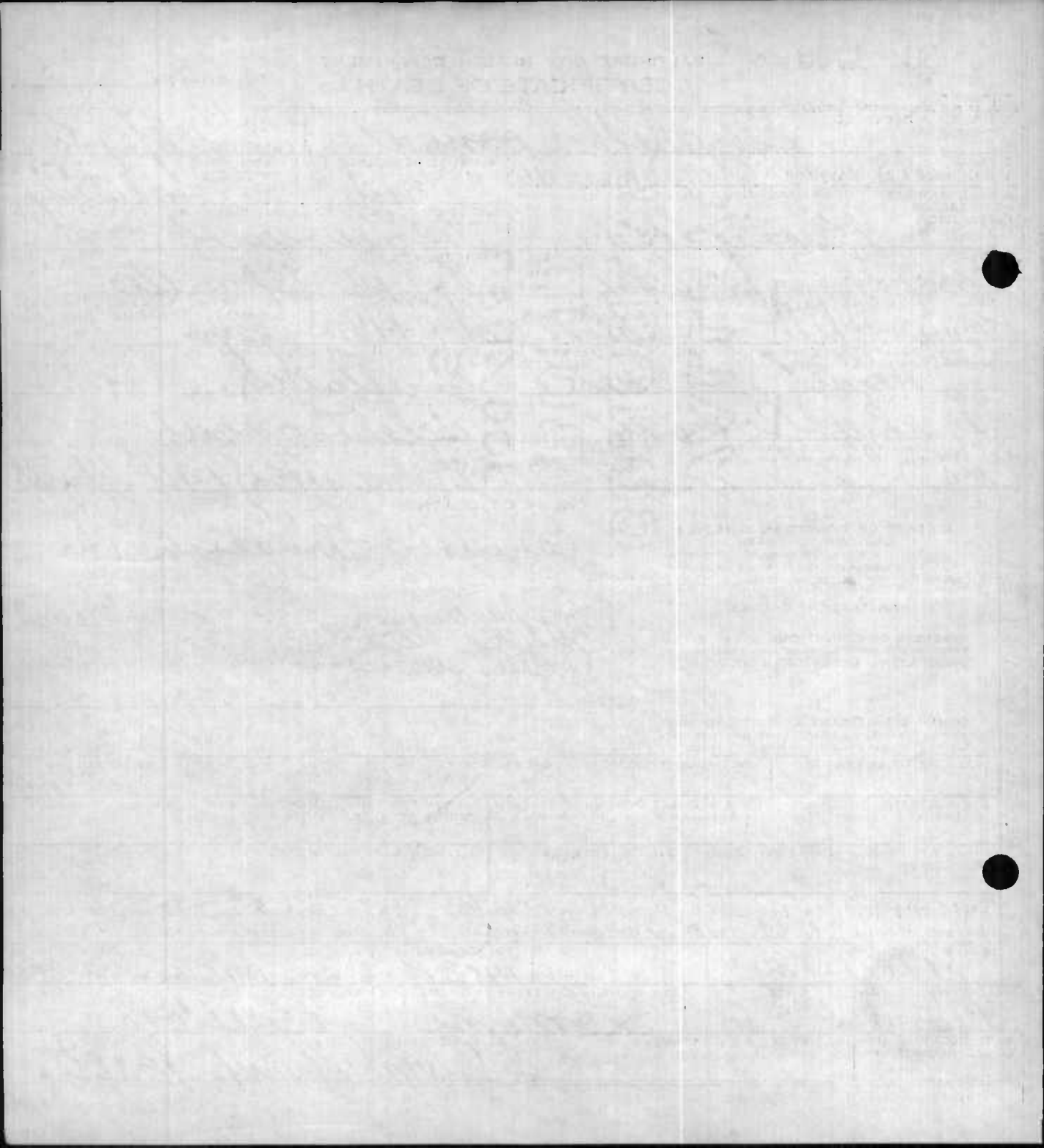
25. FUNERAL DIRECTOR

ADDRESS

MAR 1 1950

Stewart Morris

Stewart Morris Balto.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1800
Registered No.

5-315
50 1800
5-315
BIRTH NO.

1. NAME OF DECEASED (Type or Print) LIVID		2. DATE OF DEATH February 26, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 626 George Street		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH Feb 12-1900
9. AGE (In years last birthday) 50		10. CITIZENSHIP (If Under 1 Year Months: Days; If Under 24 Hours Hours: Min.)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Fairmount N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Stephens		14. MOTHER'S MAIDEN NAME Amorette Powell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 216-01-3481	
17. INFORMANT Mrs Regina Mallory		ADDRESS 1407 N. Colvin St	

18. 470.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
(C)		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE RS Fisher		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED 2-27-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/3/50		24C. NAME OF CEMETERY OR CREMATORY Fairmount N.C.	
24D. LOCATION (City, town, or county) (State) Fairmount N.C.		24E. FUNERAL DIRECTOR Joseph J. Russ		ADDRESS -1200 McCulloch St	
24F. DATE RECEIVED BY LOCAL REGISTRAR		24G. REGISTRAR'S SIGNATURE		24H. DATE	

MEDICAL CERTIFICATION

MAR 1 1950
VS 151

75081

937 ✓

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
Date of Death		Time of Death		Place of Death	
Cause of Death		Disease		Signature of Physician	
Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
Signature of Burial Officer		Signature of Undertaker		Signature of Cemetery	
Signature of Funeral Home		Signature of Religious Society		Signature of Other	

W-320
50 1801BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1801
Registered No.

BIRTH NO. 49-09198

1. NAME OF DECEASED
(Type or Print)

THOMASINA WOODS

2. DATE
OF
DEATH

Feb 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

BALTO.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Maryland 25-32

D. STREET ADDRESS (If rural, give location)

2711 BEREA RD

5. SEX

F

6. COLOR OR RACE

CO

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

L

8. DATE OF BIRTH

2/4/49 (23)

9. AGE (In years,
last birthday)

11 1/2 Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

INFANT

10B. KIND OF BUSINESS OR INDUSTRY

IT

13. FATHER'S NAME

JAMES EDWARD WOODS

14. MOTHER'S MAIDEN NAME

BERNICE BUCKNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

FATHER

ADDRESS

SAME

18. ~~FF3X~~ 391.2

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ESOPHAGEAL REFUXATION

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) MEDIASTINITIS

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) OTITIS MEDIA

(over)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2/28, 1950, to 2/28, 1950, that I last saw the deceased alive on 2-28, 1950 and that death occurred at 10:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Leonard Bachner

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

2/29/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Arlington Memorial Park

24D. LOCATION (City, town, or county)

Brooklyn Park

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Joseph J. Russ 1200 McCulloch St

ART VS 1950

19500001803

89a

See Document File 58-1801

also:

From autopsy report, etc received
from University, ~~Do Falls~~ and
discussions with Dr Fisher by phone

4-21-50 Dr Faler recognized otitis media
as underlying cause

81.

4-21-50

46 B 72.

RECEIVED
JAN 10 1964

412



A-325

50 1803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1803

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

IDA

MAY

ADDISON

2. DATE
OF
DEATH

February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Bon Secours Hospital

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

527 S. Fulton Avenue

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 15, 1898

9. AGE (In years
last birthday)

51

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

Own home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Kramer

14. MOTHER'S MAIDEN NAME

Alice Wilkins, 527 S. Fulton Ave.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Edward R. Addison, 527 S. Fulton

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

*P. J. Sullivan*23B. CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
M.D. MEDICAL INVESTIGATOR ☒23C. DATE SIGNED
2-27-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Pk.

24D. LOCATION (City, town, or county)

Woodlawn, Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAY 1 1950

Harvey N. White, 4101 Edmond

937

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

1900

1900

635

50 1804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50 1804

1. NAME OF DECEASED
(Type or Print)

MARY CATHERINE LARDNER

2. DATE OF DEATH
2/26/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

600 East 28th Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 9-04

C. Length of stay in Baltimore life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location)
600 East 28th Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

1884

9. AGE (In years last birthday) 66 If Under 1 Year Months: Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife10B. KIND OF BUSINESS OR INDUSTRY
at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Thomas Dempsey

14. MOTHER'S MAIDEN NAME

(?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
no -16. SOCIAL SECURITY NO.
-

17. INFORMANT

ADDRESS

Mrs. E. Burgan-803 Arlington Ave

18. 443 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Hypertensive Cardio-Vascular Dis

10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO
(C)II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Nov. 47, to 26 Feb, 1950, that I last saw the deceased alive on 26 Feb, 1950, and that death occurred at 6 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Edward Z. J. Krieg

M. D.

23B. ADDRESS

4508 Edmonson Village

23C. DATE SIGNED

1 March '50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cem

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

WIEDEFFELD & SON

GREENMOUNT AVE & 22ND.

MAR 1 1950

190500001808

93D

MEDICAL CERTIFICATION

WILLIAM

222 222 222

1000

244202

A 2 11

CERTIFICATE CORRECTED 3-14-50

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS LEROY O'CONNOR

2. DATE
OF
DEATH

3-1-50
6/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

709 East 22nd Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

709 East 22nd Street

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1887

9. AGE (in years last birthday)

63

If Under 1 Year Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Asst Freight Agent

10B. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Pittsburgh, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jeremiah O'Connor

14. MOTHER'S MAIDEN NAME

Bradget Fields

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT 709 E. 22nd Street
Mrs. Minnie O'Connor

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

11 days

DOE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertension

2 years

DOE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 2-17 to 2-28, 1950, that I last saw the deceased alive on 2-29, 1950, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/3/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem

24D. LOCATION (City, town, or county) (State)

City

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

WIEDEFELD AND SON

GREENMOUNT AVE. & 22nd ST.

AR 1 950

244 47

83a

MEDICAL CERTIFICATION

WILEY
CONGREGATIONAL
CHURCH

500
50 1806BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1806
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LAWRENCE

JAMES

OIEN

2. DATE
OF
DEATH

February 25, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

St. Agnes Hospital

Yrs.
Mos.
Days4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
New YorkC. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

New York

D. STREET ADDRESS (If rural, give location)

25 South Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

12-16-1902

9. AGE (In years
last birthday)

47

If Under 1 Year
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Seaman

10B. KIND OF BUSINESS OR
INDUSTRY11. BIRTHPLACE (State or foreign country)
Spokane Wash.12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Charles M. Oien

14. MOTHER'S MAIDEN NAME

Lettie Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Tod Oien Spokane Wash.

18. E 812.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fracture of skull
DUE TO Ruptured kidney
Ruptured liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)
street21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)
Washington Blvd., Elkridge, Md.21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

February 25, 1950

? Am.

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by trailer truck

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....23C. DATE SIGNED
2-25-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3-2-1950

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National

24D. LOCATION (City, town or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

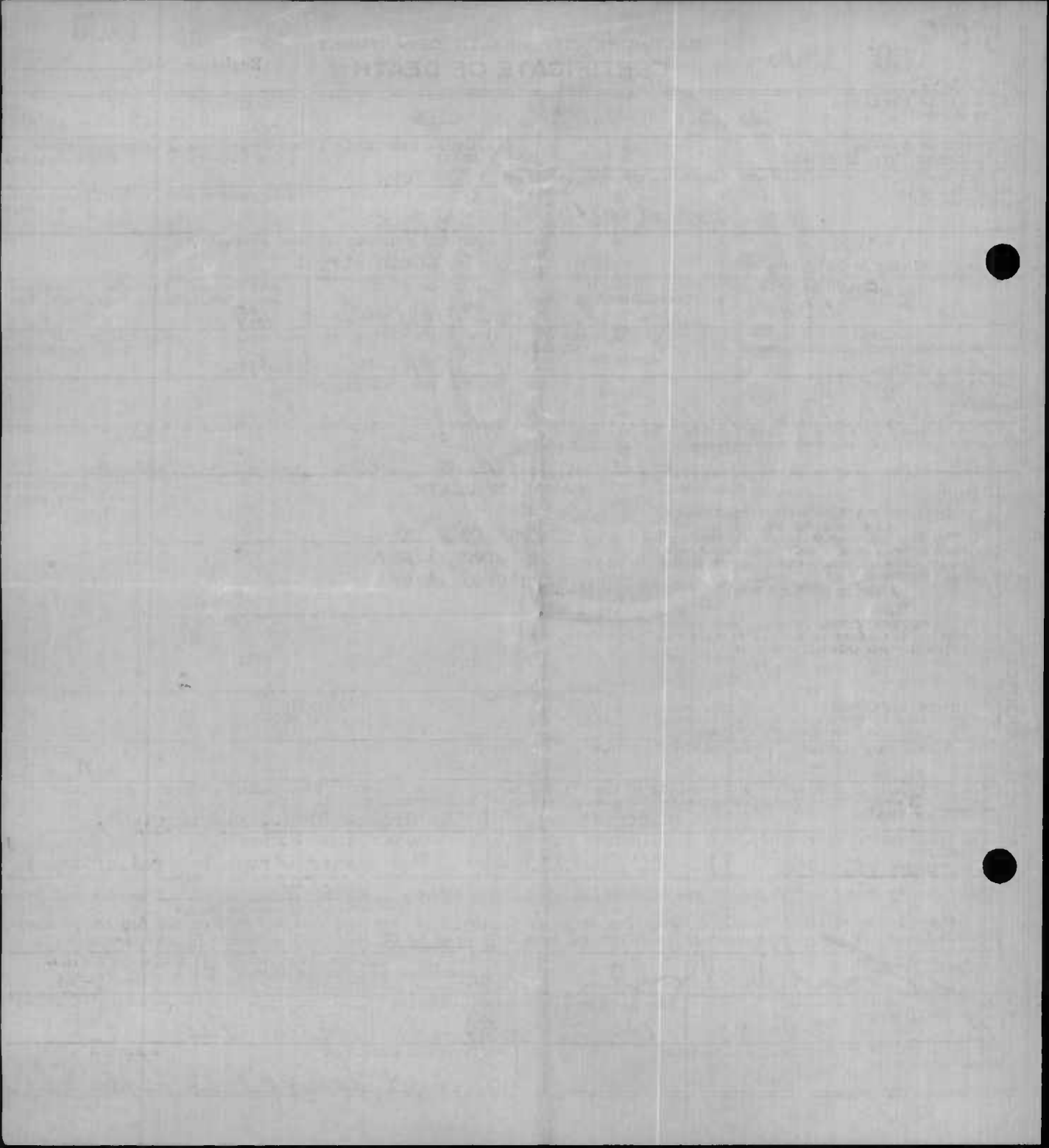
Flynn & Fleming 1426 Light St.

VS 151

MAR 1 1950 N-80312

46051

1700



620
50 1807

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

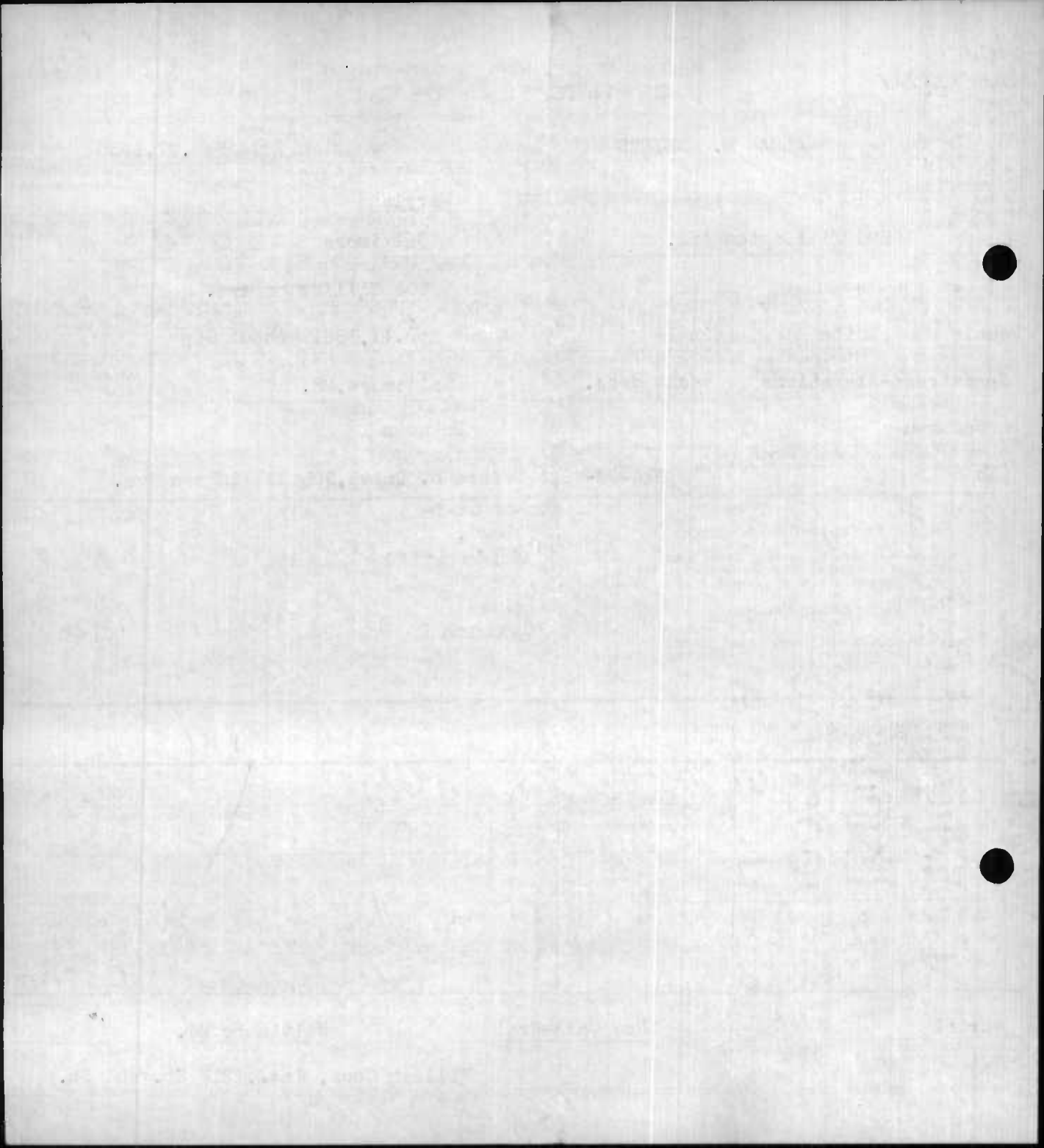
50 1807
Registered No.

1. NAME OF DECEASED (Type or Print) ALMA M. MEYERS			2. DATE OF DEATH Feb. 27, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland		
B. FULL NAME OF HOSPITAL OR INSTITUTION 503 Millington Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-05		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 503 Millington Ave.		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH About Apr. 11, 1881		9. AGE (in years last birthday) About 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress-Alterations			10B. KIND OF BUSINESS OR INDUSTRY Hecht Bros.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Unknown		
14. MOTHER'S MAIDEN NAME Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		
16. SOCIAL SECURITY NO. 215-09-7527			17. INFORMANT ADDRESS Anna B. Smith, 503 Millington Ave.		

18. 155X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Gall Bladder	CAUSE OF DEATH (A) Carcinoma of Gall Bladder DUE TO (B) Carcinoma of Gall Bladder DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH 4 months 1 year
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION Dec 20, 1949		19B. MAJOR FINDINGS OF OPERATION Carcinoma of gall bladder		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec 20 , 19 49 , to Feb 27 , 19 50 , that I last saw the deceased alive on Feb 25 19 50 , and that death occurred at 3:00 P.m. , from the causes and on the date stated above.					
23A. SIGNATURE Wm Michel M.D.		23B. ADDRESS 1015 Poplar Grove St.		23C. DATE SIGNED Feb 28 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/2/50		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) Baltimore, Md.		25. FUNERAL DIRECTOR ADDRESS William Cook, Inc., 1217 St. Paul St.			

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MAR 2 - 1950
43463 0 9
46F



630

50 1808

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

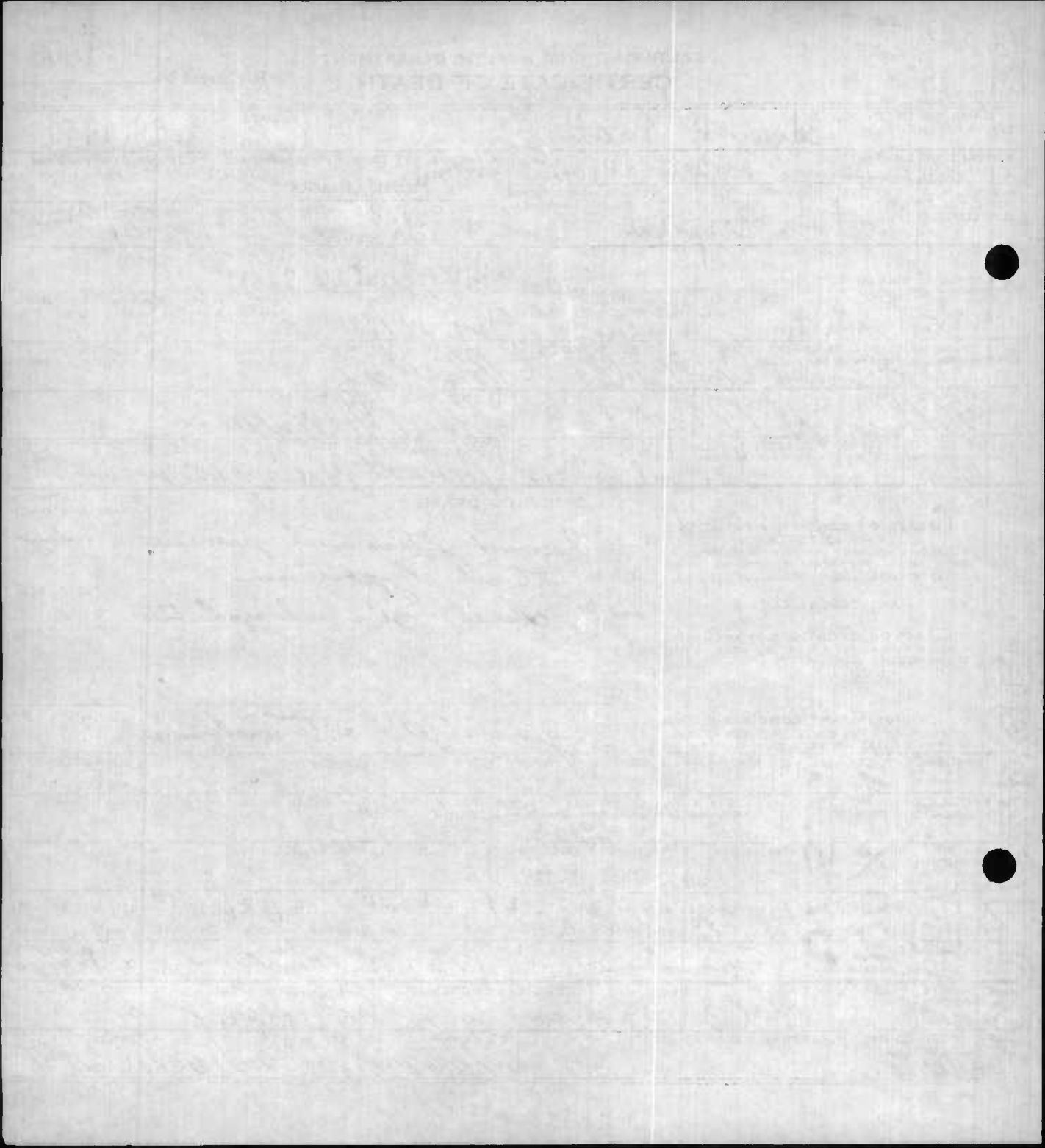
50 1808

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edgar H. Bratt		2. DATE OF DEATH 2.28.1950.	
3. PLACE OF DEATH: A. Baltimore City, Maryland Doctor's Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Doctor's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-01	
D. STREET ADDRESS (If rural, give location) 1407 Eustaw Pl 17		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Jan. 18-1881
9. AGE (In years last birthday) 69		10. UNDER 1 YEAR Months: Days	
11. UNDER 24 HOURS Hours: Min.		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) watchman		10B. KIND OF BUSINESS OR INDUSTRY Condor Bldg.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H Bratt		14. MOTHER'S MAIDEN NAME Louise J. Fullum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 218-26-0198	
17. INFORMANT William H. Bratt, 1103 1/2 Shubert St		ADDRESS	
18. 592 X CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
(A) Increased intracranial pressure			
DUE TO arterial hypertension			
(B) chronic glomerulonephritis			
DUE TO			
(C) generalized arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH 1 day			
? ?			
? ?			
? ?			
19A. DATE OF OPERATION			
19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/22/1950 , to 2/28/1950 , that I last saw the deceased alive on 2/28/1950 , and that death occurred at m. , from the causes and on the date stated above.			
23A. SIGNATURE Dr. Friedman M. D.		23B. ADDRESS 1737 E. North Ave	
23C. DATE SIGNED 2/28/50		24A. BURIAL, CREMATION, REMOVAL (Specify)	
24B. DATE 3/3/50		24C. NAME OF CEMETERY OR CREMATORY Lorraine	
24D. LOCATION (City, town, or county) (State) Woodlawn Md		DATE RECEIVED BY LOCAL REGISTRAR MAR 2 - 1950	
REGISTRAR'S SIGNATURE William H. Bratt		25. FUNERAL DIRECTOR William H. Bratt	
ADDRESS 1219 1/2 Paul St		ADDRESS	

MEDICAL CERTIFICATION



532

50 1809

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1809

Registered No.

1. NAME OF DECEASED (Type or Print) AGNES MOORE BENEDICT		2. DATE OF DEATH March 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 4-02	
B. FULL NAME OF HOSPITAL OR INSTITUTION 551 W. Lexington St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 651 W. Lexington St.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Nov. 13, 1867
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At. Home	9. AGE (In years last birthday) 82 If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) Marquette, Mich		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thoma s Moore		14. MOTHER'S MAIDEN NAME Katheleen (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Carlyle Benedict, 651 W. Lexington St.		ADDRESS	

18. 331X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage DUE TO (A) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 days
ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-28 , 19 50 to 2-28 , 19 50 , that I last saw the deceased alive on 2-28 , 19 50 , and that death occurred at 8a m. from the cause and on the date stated above.					
23A. SIGNATURE Th R Johnson M. D.		23B. ADDRESS 403 2nd Arts Bg		23C. DATE SIGNED 3/1/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/3/50		24C. NAME OF CEMETERY OR CREMATORY St. Peters	
24D. LOCATION (City, town, or county) (State) Baltimore, Md/					

DATE RECEIVED BY LOCAL REGISTRAR MAR 2 - 1950	REGISTRAR'S SIGNATURE William Cook, Inc., 1217 St. Paul St.	25. FUNERAL DIRECTOR William Cook, Inc., 1217 St. Paul St.	ADDRESS
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DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY

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560
ES-16041
50 1810
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

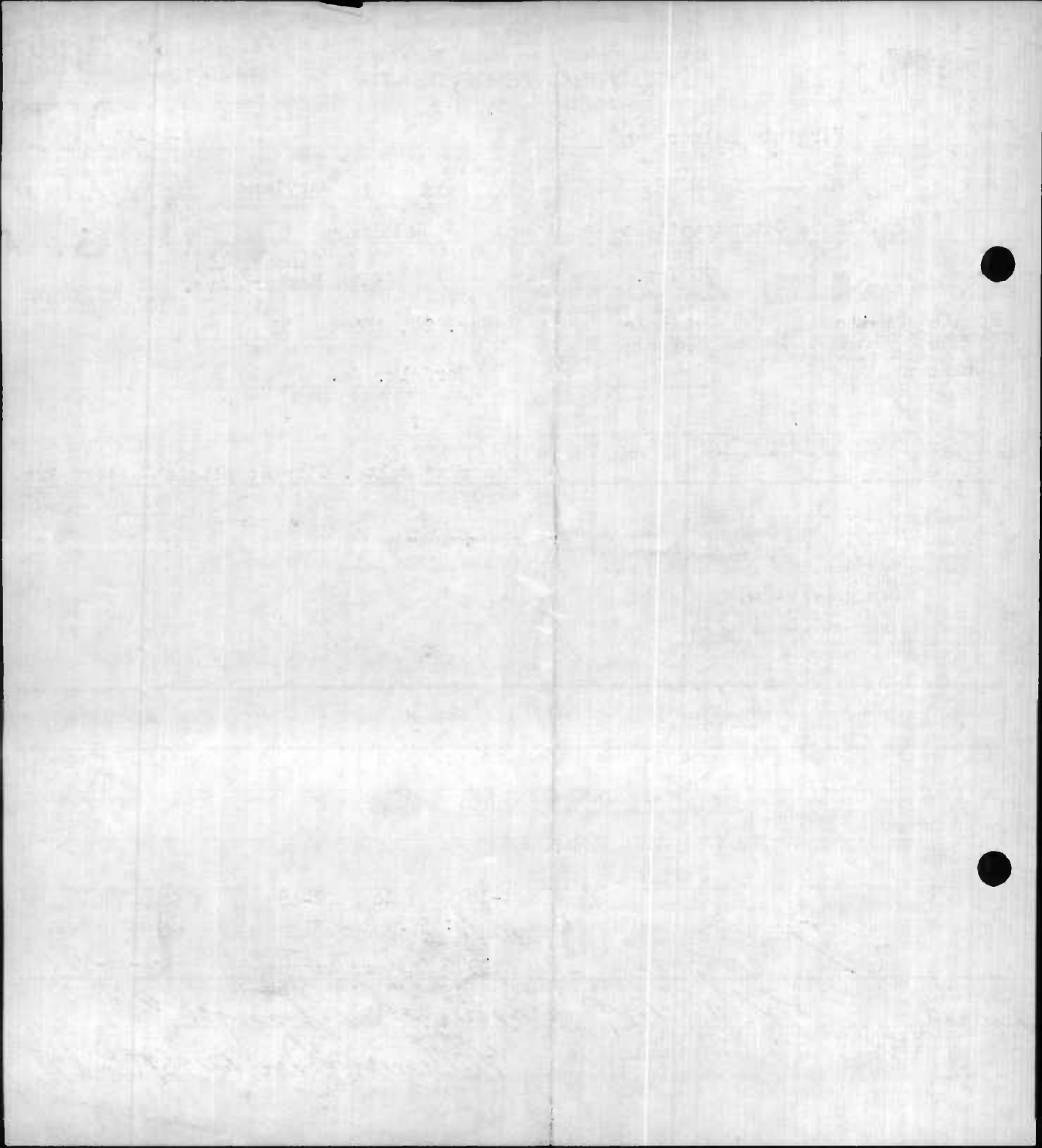
50 1810

1. NAME OF DECEASED (Type or Print) Virginia Rainer			2. DATE OF DEATH 2-18-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ma ? Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ? Baltimore 26-12		
D. STREET ADDRESS (If rural, give location) ? 4940 Eastern Ave.			E. LENGTH OF STAY IN BALTIMORE 70 Yrs.		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Mar. 24, 1868		9. AGE (in years last birthday) 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Records* Balto. City Hospitals Eastern Ave.		
18. 491X			ADDRESS 4940		

CAUSE OF DEATH

18. 491X		I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A)		Bronchopneumonia			
DUE TO							
ANTECEDENT CAUSES		(B)		DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							

19A. DATE OF OPERATION 2-18-50		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1-18 , 19 16 , to 2-18 , 19 50 , that I last saw the deceased alive on 2-18 , 19 50 , and that death occurred at 6:35 P.m. , from the causes and on the date stated above.					
23A. SIGNATURE Ch. Boyer		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 2-28-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 3/2/50		24C. NAME OF CEMETERY OR CREMATORY Not Carmel Baltimore	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR William C. Paul		ADDRESS 1219 7th St	
DATE RECEIVED BY LOCAL REGISTRAR MAR 2 - 1950		REGISTRAR'S SIGNATURE William C. Paul			



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1811

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>Henry P. Powell</u>		2. DATE OF DEATH <u>2/28/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> COUNTY <u>Harford</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>West Balto General</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto Md</u> <u>20-07</u>	
C. Length of stay in Baltimore <u>49</u> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 6 1875</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Busk Lays</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self-</u>	9. AGE (In years, last birthday) <u>75</u>
11. BIRTHPLACE (State or foreign country) <u>Summerset Co Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Powell</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Miles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-12-1849</u>	17. INFORMANT <u>Bertram Powell</u>
ADDRESS		ADDRESS	

18. <u>331X</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>Cerebral Hemorrhage</u> DUE TO (B) <u>Hypertension</u> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <u>6 Hours</u>
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 28, 1950, to Feb. 28, 1950, that I last saw the deceased alive on Feb. 28, 1950, and that death occurred at 7:40 p. m., from the causes and on the date stated above.

23A. SIGNATURE <u>Reverend Geyer</u>		23B. ADDRESS <u>301 W. Baltimore St.</u>		23C. DATE SIGNED <u>3/1/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>3/3/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Ceme</u>	
24D. LOCATION (City, town, or county) <u>Friedrich Rd</u>		24E. LOCATION (City, town, or county) <u>Friedrich Rd</u>		(State)	
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 2 - 1950</u>		REGISTRAR'S SIGNATURE <u>Chas P. Towell</u>		25. FUNERAL DIRECTOR <u>Chas P. Towell</u>	
ADDRESS		ADDRESS		ADDRESS	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Occupation		Marital Status	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	

540

DONNELLY
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1812

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Margaret A. Donnelly*2. DATE
OF
DEATH*3/1/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore City*4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE *Maryland* B. COUNTY *Anne Arundel*B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE*West Baltimore General Hosp*C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Glen Burnie

C. Length of stay in Baltimore

*Life*Yrs.
Mos.
DaysD. STREET ADDRESS (If rural, give location)
422 Chain Highway

5. SEX

F

6. COLOR OR RACE

*W*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*M*

8. DATE OF BIRTH

*FEB 21/1883*9. AGE (In years;
last birthday)*67*If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

*BALTIMORE MD*12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

HARRY DOWNES

14. MOTHER'S MAIDEN NAME

*ELIZABETH ROESE*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

*JOHN F. DONNELLY*18. *550.1*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Peritonitis*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Ruptured Appendix*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2/24*, 1950, to *3/1*, 1950, that I last saw the deceased alive on *3/1*, 1950, and that death occurred at *12⁰⁵* A.m., from the causes and on the date stated above.

23A. SIGNATURE

William H. Wood

M. D.

23B. ADDRESS

West Balt. General Hosp

23C. DATE SIGNED

*3/1/50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3/4/50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven Ceme

24D. LOCATION (City, town, or county) (State)

*Glenburnie*DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

MAK 2-135
William H. Wood

25. FUNERAL DIRECTOR

ADDRESS

Chas P. Towell. 2427 Edmondson Ave

UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

REPORT OF INVESTIGATION
DATE: 10-1-68

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10-1-68

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

620
50 1813BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1813

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND W. PARKS		2. DATE OF DEATH February 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 1607 Cole Street		19-04	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 5, 1907
9. AGE (In years last birthday) 42		If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chauffer		10B. KIND OF BUSINESS OR INDUSTRY Taxi Cab Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry A. Parks		14. MOTHER'S MAIDEN NAME Katherine Deck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. X19-05-5346	
17. INFORMANT Alice N. Parks		ADDRESS 1607 Cole Street	

18. **E 816.4**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Rupture of aorta**
DUE TO
Fracture, right femur.
(B) **Multiple rib fractures**
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

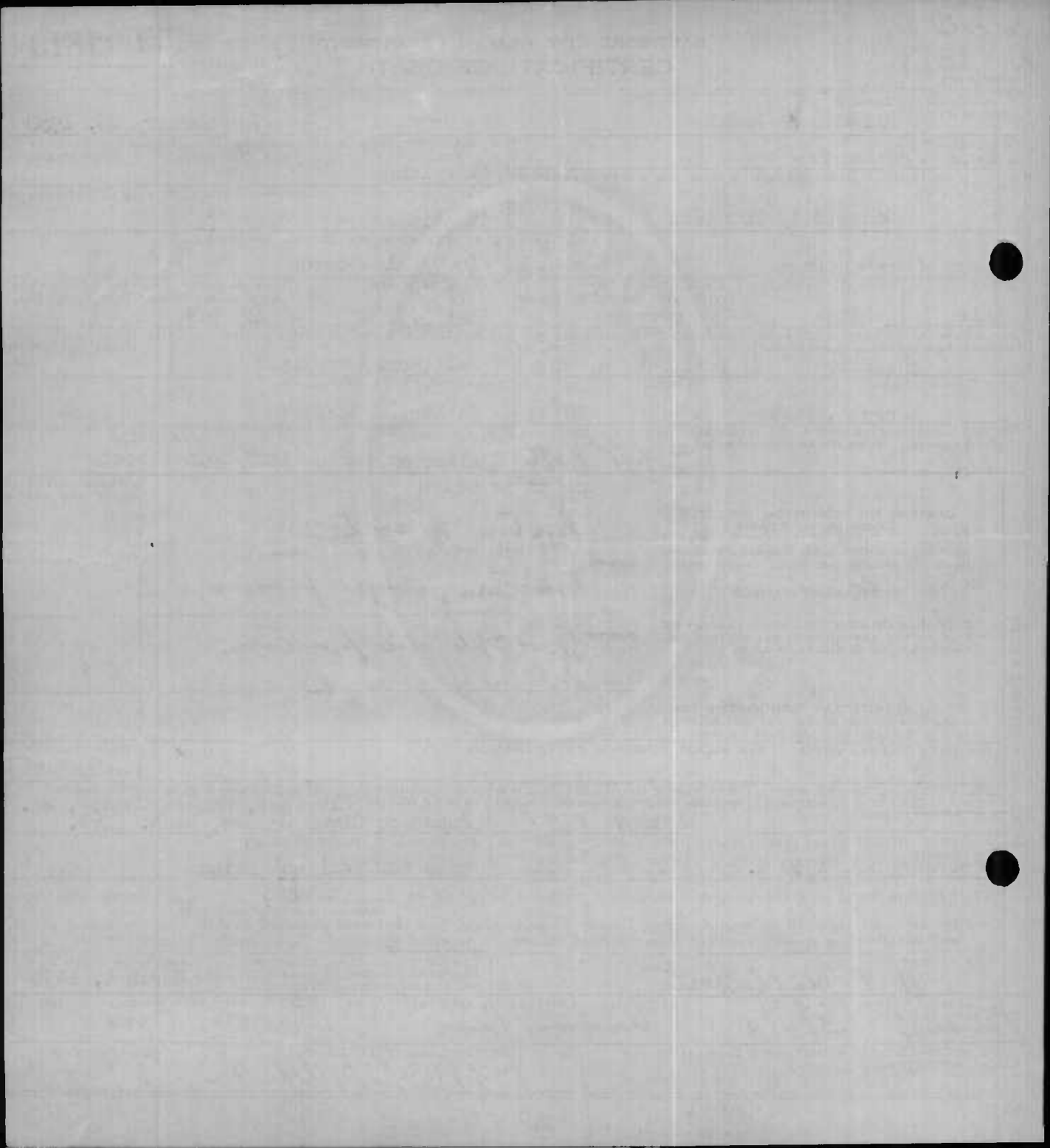
II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Elkridge, Howard County, Md. Patapsco River Bridge, Wash. Blvd.	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY February 28, 1950 2.25a.m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? auto and taxi collision	

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE H. J. Mc Clafferty		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED March 1, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/4/50		24C. NAME OF CEMETERY OR CREMATORY London Park	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25. FUNERAL DIRECTOR John C. P. M. Walters		ADDRESS Strickland	
DATE RECEIVED BY LOCAL REGISTRAR MAR 2 - 1950		REGISTRAR'S SIGNATURE William H. Williams		ADDRESS	



652
50 1814

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1814

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George Barnes			2. DATE OF DEATH 2-27-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTO		
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto, Md		
D. STREET ADDRESS (If rural, give location) 720 Vine Street			E. LENGTH OF STAY IN BALTIMORE 10 yrs.		
5. SEX male	6. COLOR OR RACE negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH July 30-1908		9. AGE (In years last birthday) 41
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Truck Driver	11. BIRTHPLACE (State or foreign country) Green Co., N. Carolina		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Barnes			14. MOTHER'S MAIDEN NAME Mary Jane Ellis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 243-16-1242	17. INFORMANT Willie Barnes ADDRESS 720 Vine St		

MEDICAL CERTIFICATION

18. 446.X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) UREMIA		DUE TO		2 wks	
ANTECEDENT CAUSES		(B) Nephrosclerosis		1 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO Malignant Hypertension		2 years	
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

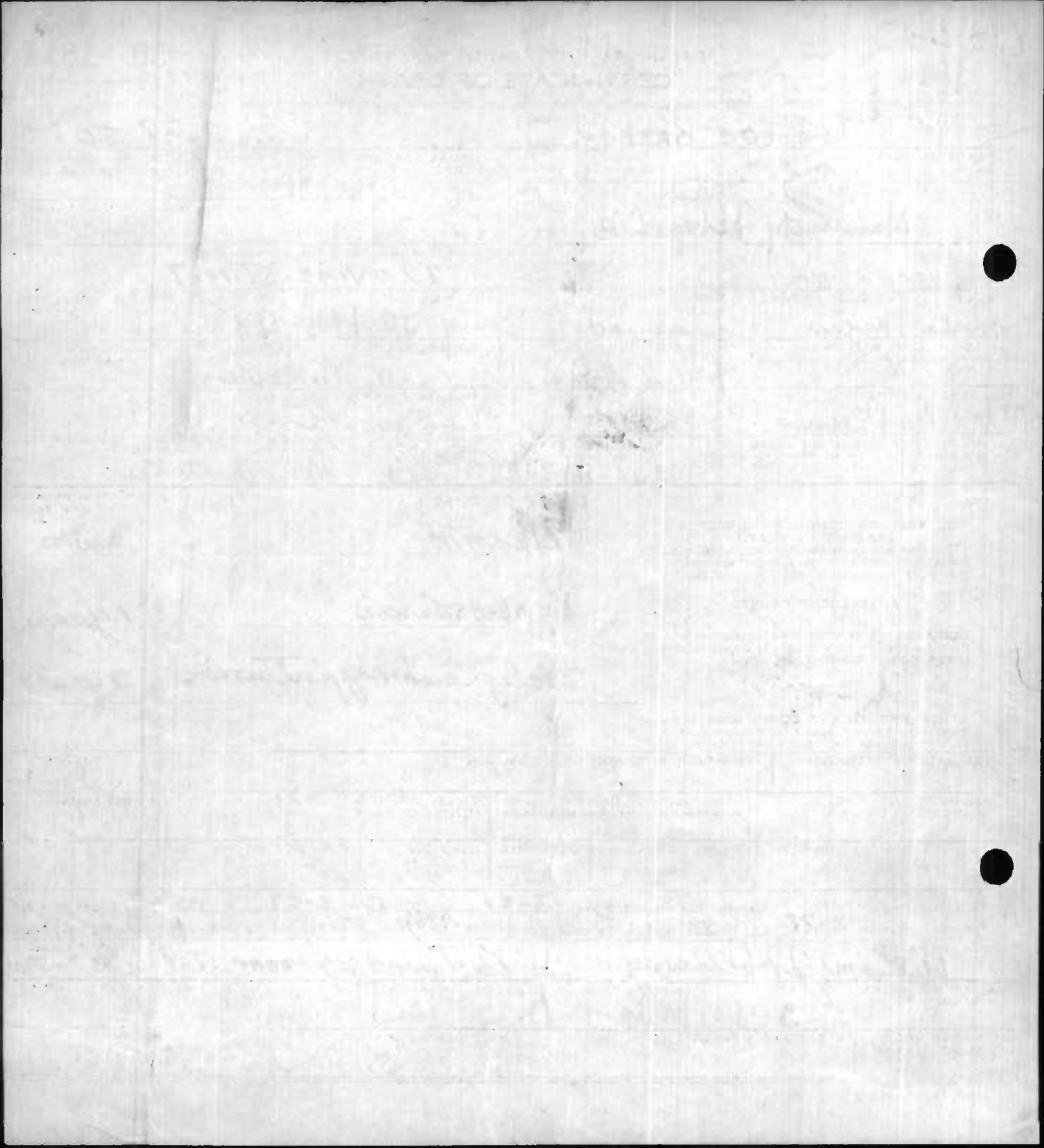
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2-21**, 19**50** to **2-27**, 19**50**, that I last saw the deceased alive on **2-27**, 19**50**, and that death occurred at **1:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE William J. Holloway M. D.		23B. ADDRESS Redwood & Greene STS		23C. DATE SIGNED 2-27-50	
---	--	--	--	---------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE 3-3-50		24C. NAME OF CEMETERY OR CREMATORY Wilson N. Carolina		24D. LOCATION (City, town, or county) (State) N. Carolina	
---	--	-------------------------	--	--	--	--	--

DATE RECEIVED BY LOCAL REGISTRAR MAR 2-1950		REGISTRAR'S SIGNATURE William J. Holloway		25. FUNERAL DIRECTOR Walter B. Spriggs ADDRESS 139 W. Harding St	
--	--	--	--	--	--



1. PLACE OF DEATH:

(a) Baltimore City, Maryland 6012 Old Harford Rd.(b) Street address 3012 Louise Ave

Hospital or institution:

ECM Hill Nursing HomeLength of stay in hospital or inst. (yrs., mos., or days) 2 days(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —(c) City or town BALTO. Md. (If outside city or town limits, write RURAL and give town)(d) Street No. 3012 LOUISE AVE (If rural give location)(e) Citizen of foreign country? — (Yes or No)If yes, name country —

3 (a) FULL NAME

ANNA ELIZABETH FEHRER3 (b) If veteran, name war —3 (c) Social Security Account No. —

4. Sex

F.

5. Color or race

W.

6 (a) Single, married, widowed, or divorced.

MARRIED6 (b) Name of husband or wife Wm.6 (c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) MAY 30 1881

8. AGE: Years Months Days If less than one day

68hr. min.9. Birthplace BALTO. Md.

(Town, county, and state)

10. Usual Occupation —11. Industry or business —12. Name LUDWIG RAUBER.13. Birthplace BALTO, Md14. Maiden Name MINNIE DUFFY15. Birthplace BALTO Md.(a) Informant Mr. Raw(b) Address 3012 Louise Ave(c) Date thereof 3/2/50

(d) Date thereof (month) (day) (year)

(e) Cemetery or crematory BALTO. CemLocation BALTO. Md.18 (a) Funeral director Heemann & Son(b) Address 6067 HARFORD ROAD19 (a) MAR 2 - 1950 (Date rec'd by registrar) (b) — (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/27 1950, at 6 P. M.21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1949, to Feb. 27 1950, and that I last saw him alive on 2/27 1950.

Immediate cause of death

carcinoma, uterus

Duration

6 mos.Due to —Due to —Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —Major findings of operation: —of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —(b) Date of occurrence — at — M.

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury —23. Signature Nathan Janner M. D.Address 7101 Harford Rd Date signed 3/1/50

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see **PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION** issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

640
50 1816

SORKELL

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1816

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lucy Sorkell

2. DATE
OF
DEATH

2-28-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

929 Arlington Ave. Govans

4. USUAL RESIDENCE (Where deceased lived. If institution, give name of institution)
A. STATE B. COUNTY

929 Aspley Ave. Balt. Md. 27-10

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

929 Aspley Ave. W. Baltimore

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

July 15, 1867

9. AGE (In years,
last birthday)

82

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Hopkins

14. MOTHER'S MAIDEN NAME

Mary Madden

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Mamie Ryan 929 Arlington Av.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 2/20, 1950, to 2/28, 1950, that I last saw the
deceased alive on 2/28, 1950, and that death occurred at 11 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3-3-50

Mt. Auburn Cem

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 2 - 1950

(Mrs) Frances A. Hemsley

578 W. NIDDALE ST.

REPUBLIC OF THE PHILIPPINES
DEPARTMENT OF EDUCATION

520
50 1817LONG
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1817

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Jessie Long

2. DATE
OF
DEATH

February 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution residence
before admission)

A. STATE

B. COUNTY

Md.
Baltimore(If outside corporate limits, write RURAL and give
township)

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

1302 Binder Court

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

2-6-12

9. AGE (In years;
last birthday)

38

If Under 1 Year

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR
INDUSTRY

SHIPYARD

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 163X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Massive sudden hemorrhage
prob. spontaneous

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Left pneumonectomy

DUE TO

(C) Carcinoma of lung - left

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2-28-50

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of lung - left

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-17, 1950, to 2-28, 1950 that I last saw the
deceased alive on 2-28, 1950, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

J. M. Beck

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

2-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3-4-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Frances A. Hemsley

25. FUNERAL DIRECTOR

(Mrs) Frances A. Hemsley

ADDRESS

573 W. Biddle St

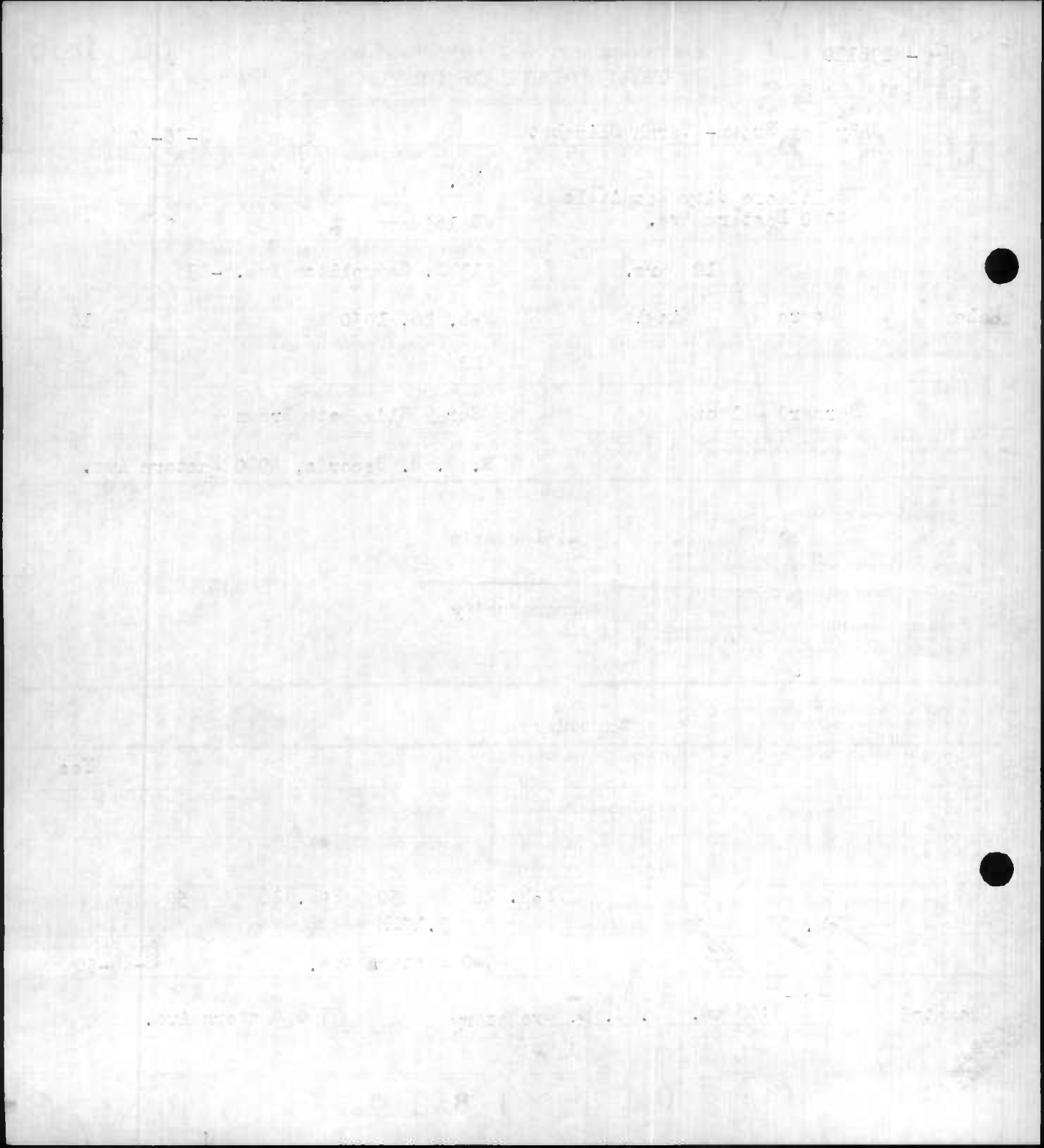
MINISTRY OF HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1911

1. Name of Deceased
2. Sex
3. Age
4. Date of Birth
5. Date of Death
6. Place of Birth
7. Cause of Death
8. Signature of Registrar
9. Signature of Medical Officer
10. Signature of Coroner

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

650 50 1818		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 1818 Registered No. _____	
BIRTH NO. <u>50-03779</u>					
1. NAME OF DECEASED (Type or Print) <u>Baby Boy Brown- Sarah Elizabeth</u>		2. DATE OF DEATH <u>2-26-50</u>			
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Ma.</u> B. COUNTY _____			
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) <u>Baltimore City Hospital (Location) 4940 Eastern Ave.</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>18-02</u>			
Length of stay in Baltimore <u>10 hrs.</u>		D. STREET ADDRESS (If rural, give location) <u>313 N. Carrollton Ave. -23</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 26, 1950</u>	9. AGE (In years last birthday)	10. Under 1 Year Months: Days <u>10</u> Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ma.</u>	
13. FATHER'S NAME <u>Bernard Dalton</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Brown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>B. C. H. Records, 4940 Eastern Ave.</u>	
18. <u>762.5</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>(A) Atelectasis</u> DUE TO <u>ANTECEDENT CAUSES</u> <u>(B) Prematurity</u> DUE TO <u>(C) Exposure</u>		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 26</u> , 19 <u>50</u> , to <u>Feb. 26</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Feb. 26</u> , 19 <u>50</u> and that death occurred at <u>3.15 PM</u> from the causes and on the date stated above.					
23A. SIGNATURE <u>[Signature]</u>		23B. ADDRESS <u>4940 Eastern Ave.</u>		23C. DATE SIGNED <u>2-28-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>		24B. DATE <u>2-28-50</u> <u>9:00 am.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>B. C. H. Crematory</u>	
24D. LOCATION (City, town, or county) (State) <u>4940 Eastern Ave.</u>					
DATE RECEIVED BY LOCAL REGISTRAR <u>MAR 2 - 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR ADDRESS	



125

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1819

BIRTH NO. 50 1819

1. NAME OF DECEASED (Type or Print) <i>Kellie Gibson</i>		2. DATE OF DEATH <i>February 27 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>10-01</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1218 W. Caroline St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
5. Length of stay in Baltimore <i>7</i> Yrs. <i>Mos.</i> <i>Days</i>		D. STREET ADDRESS (If rural, give location) <i>1218 W. Caroline St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>3/22/1880</i>
10A. USUAL OCCUPATION (Of kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <i>69</i>
13. FATHER'S NAME <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>Columbia S.C. U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <i>Hester Meyers</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. *443.X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Angiopathy*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hypertension C.V.D.*
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from *2-26*, 19*50*, to *2-27*, 19*50*, that I last saw the deceased alive on *2-26*, 19*50*, and that death occurred at *9:30* a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

correct age is especially important

RECEIVED BY THE DIRECTOR

RECEIVED BY THE DIRECTOR

516

50 1820

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1820

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alma H. Ambrose

2. DATE

OF
DEATH

Feb. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Union Memorial Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

13-07

C. Length of stay in Baltimore

30

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

3849 Roland Ave.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb 14, 1896

9. AGE (In years

last birthday)

54

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Public Relations Officer Bureau of Sanitation

10B. KIND OF BUSINESS OR INDUSTRY

Bureau of Sanitation

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert Henry Meeks

14. MOTHER'S MAIDEN NAME

Molly Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

WALTER PRICE AMBROSE 3849 ROLAND AVE

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Myocardial Infarction

3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Coronary Thrombosis

3 days

DUE TO

(C)

Arteriosclerosis

years

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Feb 26, 1950, to Feb 28, 1950, that I last saw the deceased alive on Feb 28, 1950, and that death occurred at 2:10 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Merrill F. Teller M. D.

23B. ADDRESS

U M Corp.

23C. DATE SIGNED

2-28-50

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 2 - 1950

Merrill F. Teller, M.D.

R. Surgee Funeral Home 3631 Fall Road

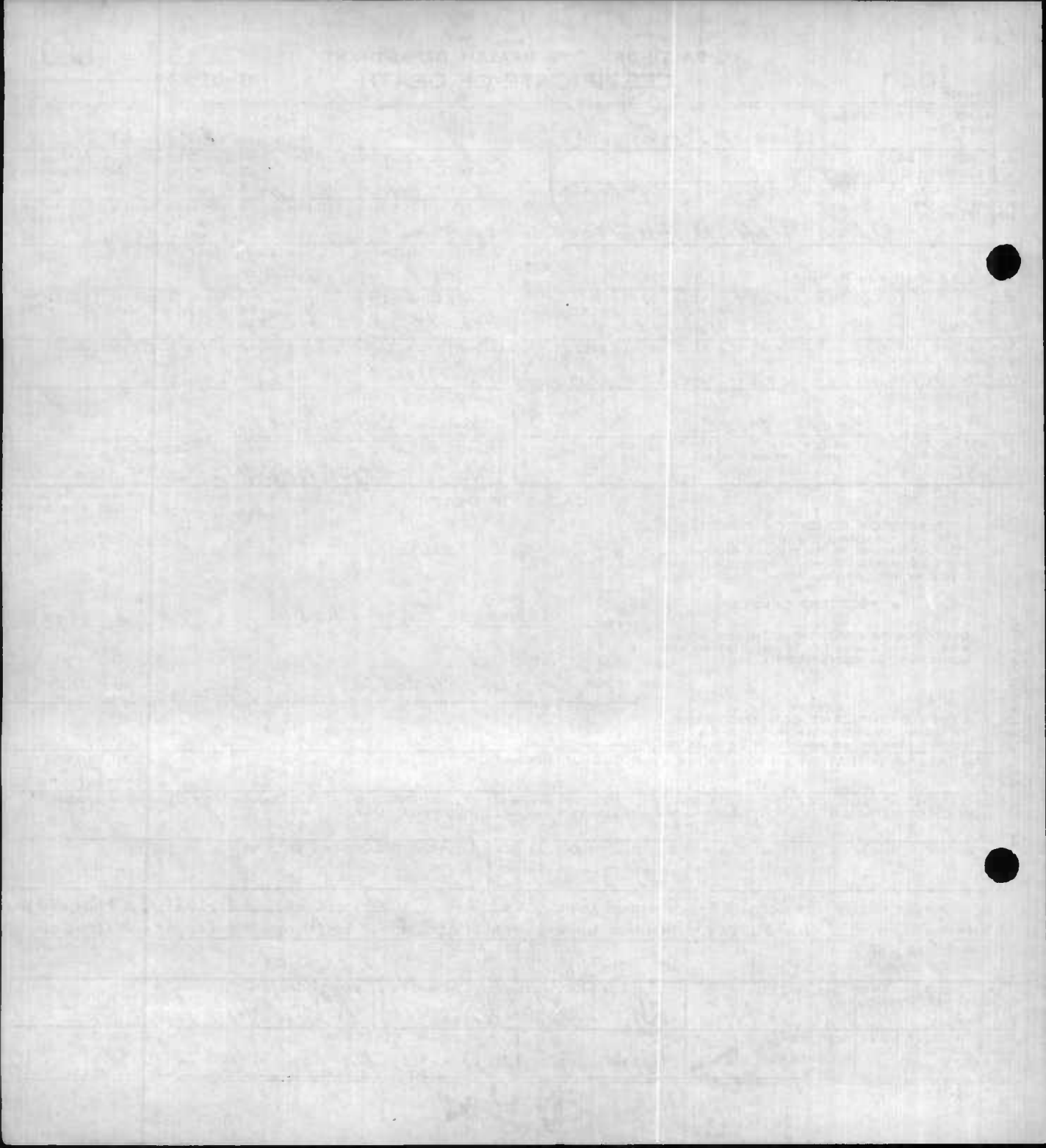
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Vol 98 2 2

94a

Correct age is extremely important. Incomplete entries are cause for rejection.



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1821

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEON H. Tessier

2. DATE
OF
DEATH

Feb. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE MASS.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

SOUTHBRIDGE

D. STREET ADDRESS (If rural, give location)

116 RIVER ST.

Length of stay in Baltimore

UNKNOWN

5. SEX
M

6. COLOR OR RACE
W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4/2/1918

9. AGE (In years
last birthday)

31

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

SOLDIER

10B. KIND OF BUSINESS OR
INDUSTRY

U.S. ARMY

11. BIRTHPLACE (State or foreign country)

MASS.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

U.S. ARMY Ft. MEADE, Md.

18. EF 16.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Crushed skull

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

Street

Rt.

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? Patapsco River Bridge, Wash.

#1 Howard Co., Elkridge, Md.

Bldv.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Feb. 28, 1950 2:25 Am.

21E. INJURY OCCURRED

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Auto into taxi

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE

Ph. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

Feb. 28, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

REMOVAL

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

SOUTHBRIDGE

24D. LOCATION (City, town, or county)

SOUTHBRIDGE, MASS.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

WILLY ZEILER INC. BALTO. MD.

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Minister of Religion

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Interment

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

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Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

Signature of Burial

530
1822BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1822

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ronald

Linto

2. DATE
OF
DEATH

Feb. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION University Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE Michigan

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Detroit

D. STREET ADDRESS (If rural, give location)

1404 Jefferson St.

Length of stay in Baltimore

UNKNOWN

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

SOLDIER

10B. KIND OF BUSINESS OR
INDUSTRY

U.S. ARMY

13. FATHER'S NAME

SYLVESTER LINTO

8. DATE OF BIRTH

5/23/1930

9. AGE (In years
last birthday)

19

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

MICHIGAN

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

CUMMINGS CYRILLO

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

U.S. ARMY Ft. MEADE, Md.

18. E816.4

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Subarachnoid Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Multiple fractures - right leg,
right forearm

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR? Patapsco River bridge, Wash.
Blvd.
Rt. #1 Howard Co., Elkridge, Md.21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Feb. 28, 1950 2:25 A.m.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Auto into taxi

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

H. J. McClafferty

23B. CHIEF MEDICAL EXAMINER

23C. DATE SIGNED

Feb. 28, 1950

M.D.

ASSISTANT MEDICAL EXAMINER

MEDICAL INVESTIGATOR

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

REMOVAL

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

DETROIT

24D. LOCATION (City, town, or county)

DETROIT, MICHIGAN

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 2 - 1950

Willy & Zeiler Inc. BALTO. MD.

VS 151

N-809.2

608 96

170C

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNICITY

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

OCCUPATION

EDUCATION

526
1823BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1823

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Kenneth J. Finger

2. DATE
OF
DEATH

Feb. 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Mass.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

New Bedford

D. STREET ADDRESS (If rural, give location)

282 N. FRONT ST.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

SINGLE

B. DATE OF BIRTH

3/11/1925

9. AGE (In years last birthday)

24

11 Under 1 Year

Months Days

11 Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

SOLDIER

10B. KIND OF BUSINESS OR INDUSTRY

U.S. ARMY

11. BIRTHPLACE (State or foreign country)

Mass.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

16. SOCIAL SECURITY NO.

?

17. INFORMANT

ADDRESS

U.S. ARMY - Ft. MEADE, Md.

18. E8164 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Compound fracture left femur

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Multiple fractures - mandible

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐NO ☒21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR

Patapsco River Bridge, Wash. Rt. #1, Howard Co., ElkrIDGE, Md. Blvd.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

Feb. 28, 1950 2:25 A.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Auto into taxi

22. I certify that I took charge of the remains described above, held an Insp. & Inc. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Dr. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER

Feb. 28, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

New Bedford

24D. LOCATION (City, town, or county) (State)

New Bedford, Mass.

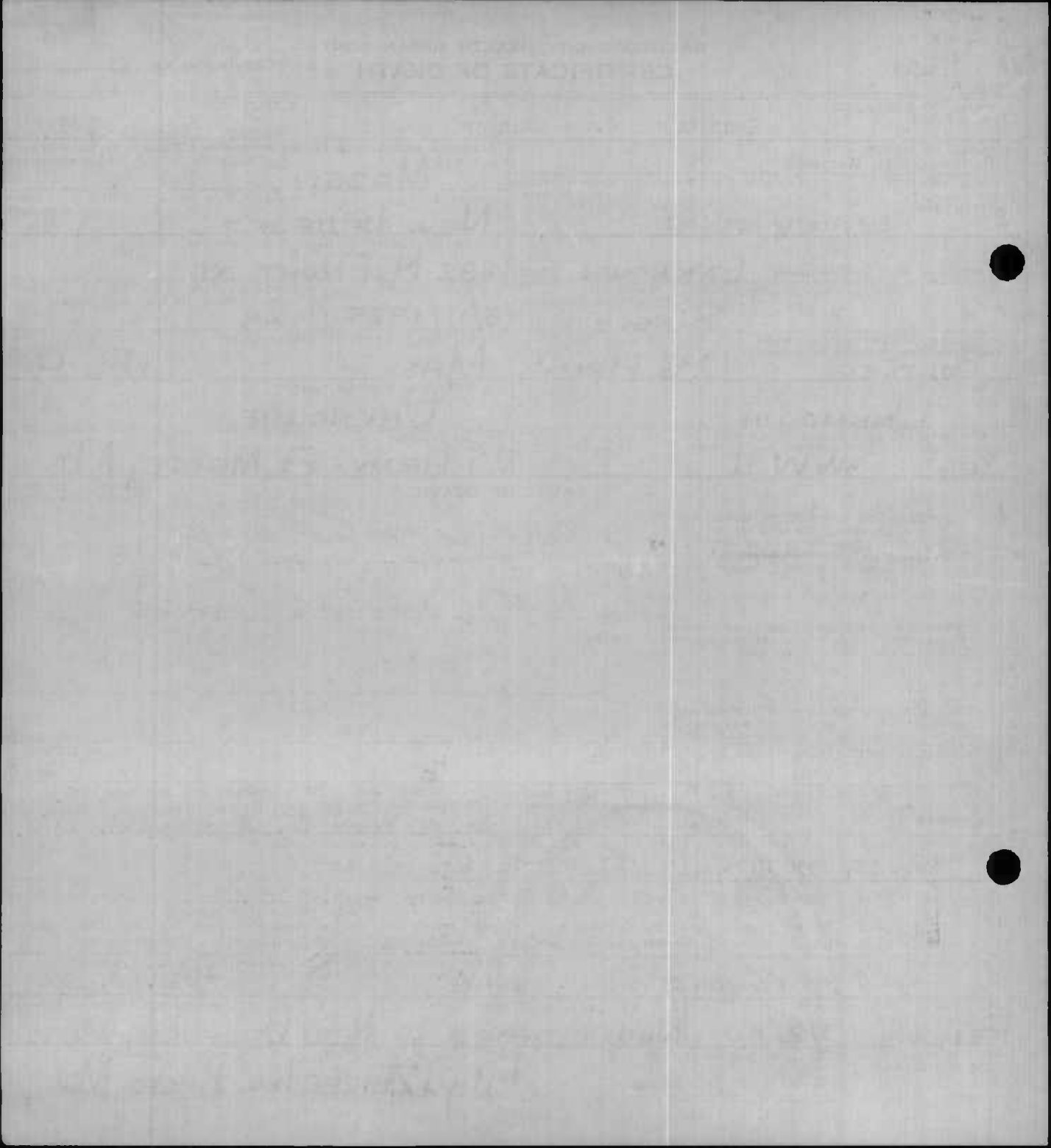
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Lilly & ZEILER INC. BALTO. MD.



263
50 1824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

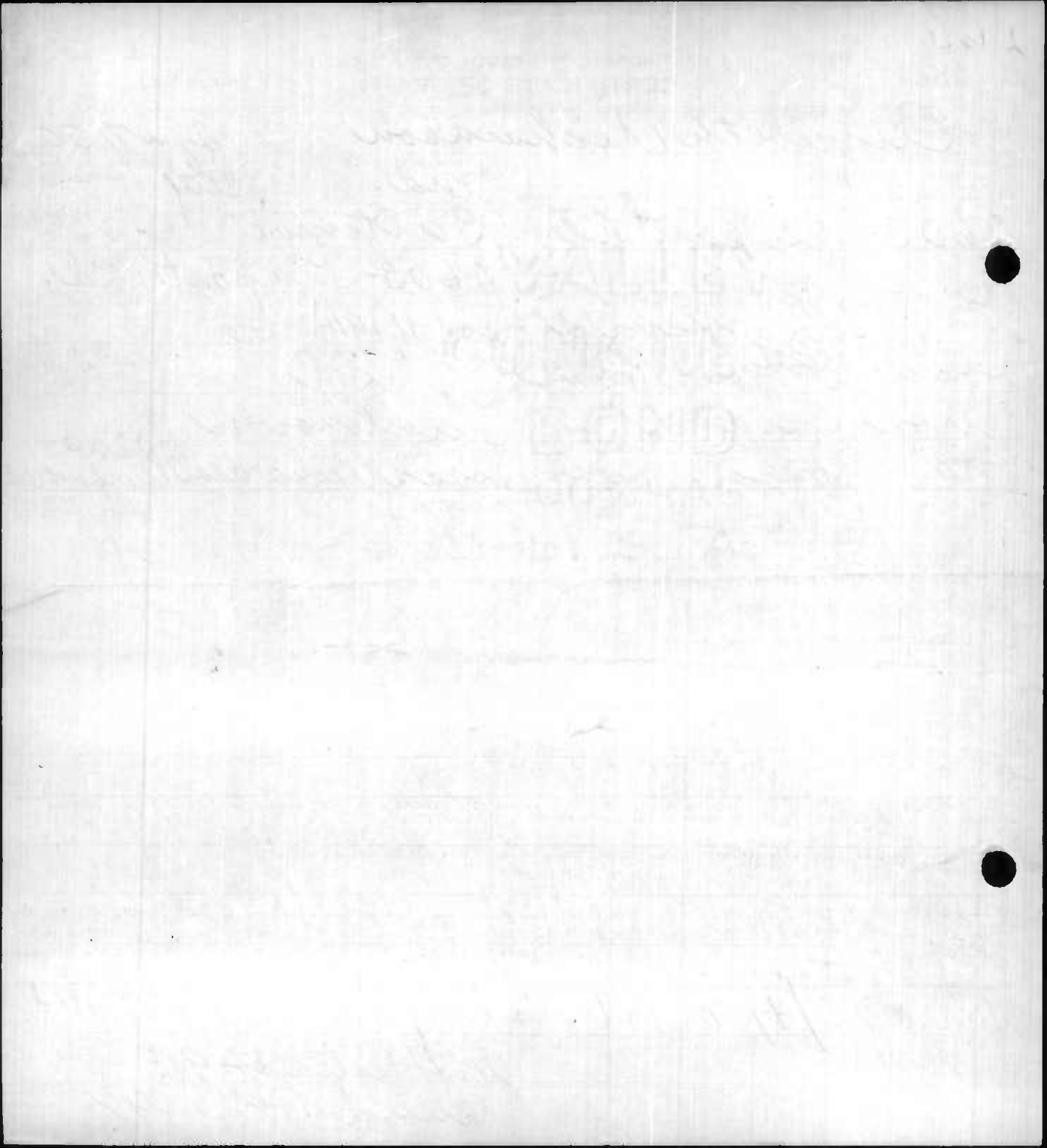
50 1824

Registered No. _____

1. NAME OF DECEASED (Type or Print) <i>Elizabeth Richardson</i>		2. DATE OF DEATH <i>2/27/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>City</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>2603-Pierpont Rd.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 25-031</i>	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>2603-Pierpont Rd.</i>	
5. SEX <i>Fr.</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Jan. 11, 1914</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	9. AGE (in years - last birthday) <i>36</i>
11. BIRTHPLACE (State or foreign country) <i>S. C.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Arion Gardner</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Isaac Richardson</i>		ADDRESS <i>2603-Pierpont Rd.</i>	

MEDICAL CERTIFICATION	18. <i>002. X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Lobar Pneumonia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
	CAUSE OF DEATH (A) DUE TO <i>Pneumonia</i>		
	(B) DUE TO <i>T-B.</i>		
	(C) _____		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>1/15/1949</i> to <i>2/27/1950</i> , that I last saw the deceased alive on <i>2/27/1950</i> , and that death occurred at <i>4:30 P. M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <i>450 W. Biddle St.</i>		23C. DATE SIGNED <i>3/2/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/4/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Wm. Calvary</i>	
24D. LOCATION (City, town, or county) <i>Cedar Hill Md.</i>		24E. (State) _____		25. FUNERAL DIRECTOR <i>A. Halstead - 918 -</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 2 - 1950</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		ADDRESS <i>Blued Hill ave. 132</i>	



416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1825

Registered No.

50 1825
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Alfred Gilbert</i>		2. DATE OF DEATH <i>2/28/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>City</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>810 - Lex. St. Apt. 6</i>		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <i>Baltimore 18-01</i>	
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>810 - Lex. St. (Apt 6) - W.</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>unknown</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>unknown</i>	
13. FATHER'S NAME <i>unknown</i>		11. BIRTHPLACE (State or foreign country) <i>Hardford Co. Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes and so unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
12. CITIZEN OF WHAT COUNTRY? <i>W. S. A.</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
17. INFORMANT <i>Olivia Gilbert - Lex. St.</i>		ADDRESS <i>810 Lex. St.</i>	

18. *331 X*
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) *Cerebral Hemorrhage*
DUE TO(B) *Arteriosclerosis*
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

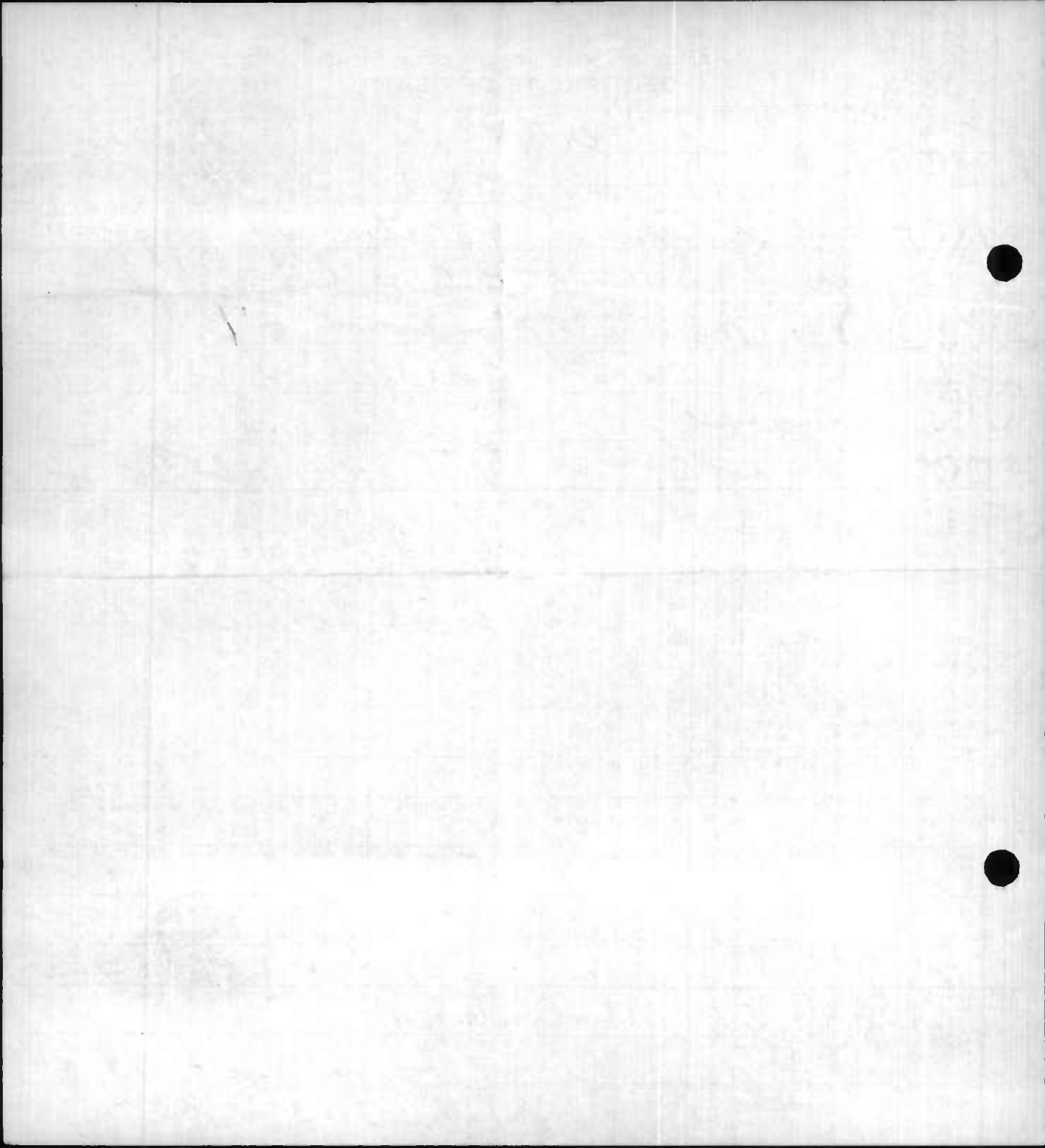
22. I hereby certify that I attended the deceased from *2-25-50*, 19*50* to *2-28-50*, 19*50*, that I last saw the deceased alive on *2-25-50*, 19*50*, and that death occurred at *2-28-50*, 19*50*, from the causes and on the date stated above.

23A. SIGNATURE <i>W. Atwell Jones</i>	23B. ADDRESS <i>534 X 0 1st St</i>	23C. DATE SIGNED <i>3-2-50</i>
---------------------------------------	------------------------------------	--------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/2/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 2 - 1950</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR <i>W. Halstead - 918 -</i>	ADDRESS <i>[Address]</i>

XIX 99141127 Hill Oct 83a

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1826

Registered No.

50 1826

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John D. Reese

2. DATE
OF
DEATH

2/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1135 - Park Ave.

4. USUAL RESIDENCE (Where deceased lived, in institution: residence
A. STATE B. COUNTY before admission)

Md. City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1135 - Park Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

unknown

9. AGE (In years;
last birthday)

60

If Under 1 Year If Under 24 Hours

Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Public Works Caterer

10B. KIND OF BUSINESS OR
INDUSTRY

Caterer

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

John Chas. Reese

14. MOTHER'S MAIDEN NAME

Nellie Klyon

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or date of service)

No

None

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Emma Reese - Park Ave.

18. 422.2

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

Several
months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 27, 1950, to Feb. 27, 1950, that I last saw the
deceased alive on Feb. 27, 1950, and that death occurred at 10 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Frank N. Gorden

M. D.

23B. ADDRESS

2701 N. Calvert St.

23C. DATE SIGNED

Mar. 1, 1950.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/2/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county) (State)

Cedar Hill Ave.

DATE RECEIVED BY
LOCAL REGISTRAR

MAR 2 - 1950

REGISTRAR'S SIGNATURE

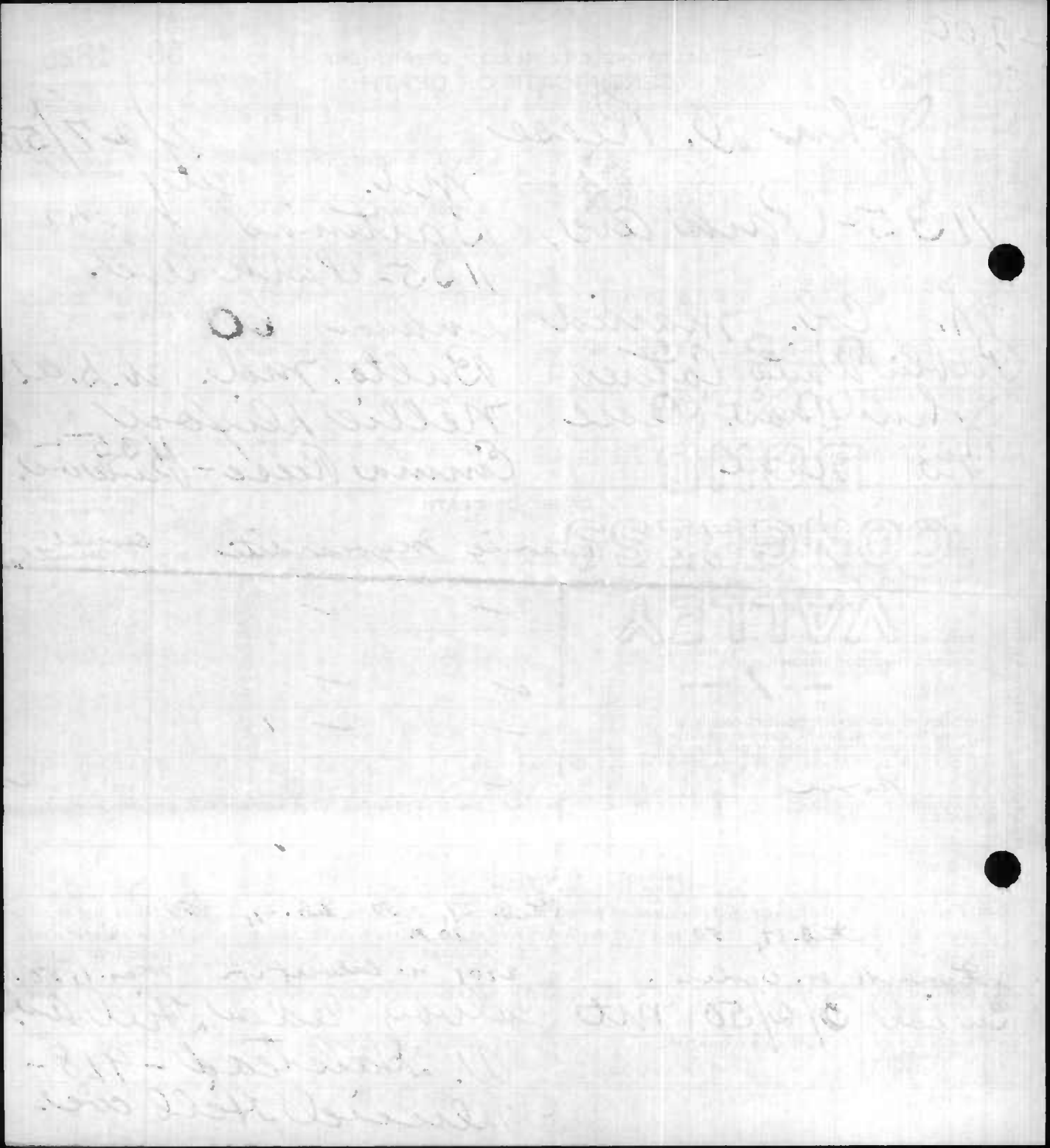
William H. Williams, Jr.

25. FUNERAL DIRECTOR

W. Halstead - 918 -

ADDRESS

7807 Mermaid Hill Ave.



363
50 1827

STEWART
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1827

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Joseph Stewart</i>		2. DATE OF DEATH <i>2-23-50</i>	
3. PLACE OF DEATH A. Baltimore City, Maryland <i>654 W. Barre</i>		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD</i> B. COUNTY <i>22-00</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN <i>Bethesda</i>	
D. STREET ADDRESS (If rural, give location) <i>654 W. Barre - BARRETT</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Col</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		8. DATE OF BIRTH _____	
9. AGE (In years, last birthday) <i>54</i>		10. Under 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saloon</i>		10B. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>James Stewart</i>		14. MOTHER'S MAIDEN NAME <i>Mary Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Maggie Stewart</i>		ADDRESS <i>654 Barre St</i>	

18. <i>420.1</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Coronary Occlusion</i>	
ANTECEDENT CAUSES	(B) _____	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION _____	19B. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from *2/21*, 19*50*, to *2/23*, 19*50*, that I last saw the deceased alive on *2/21*, 19*50*, and that death occurred at *8:15* m., from the causes and on the date stated above.

23A. SIGNATURE <i>R. B. Smith</i>	23B. ADDRESS <i>2134 D. St. N.E.</i>	23C. DATE SIGNED <i>3/1</i>
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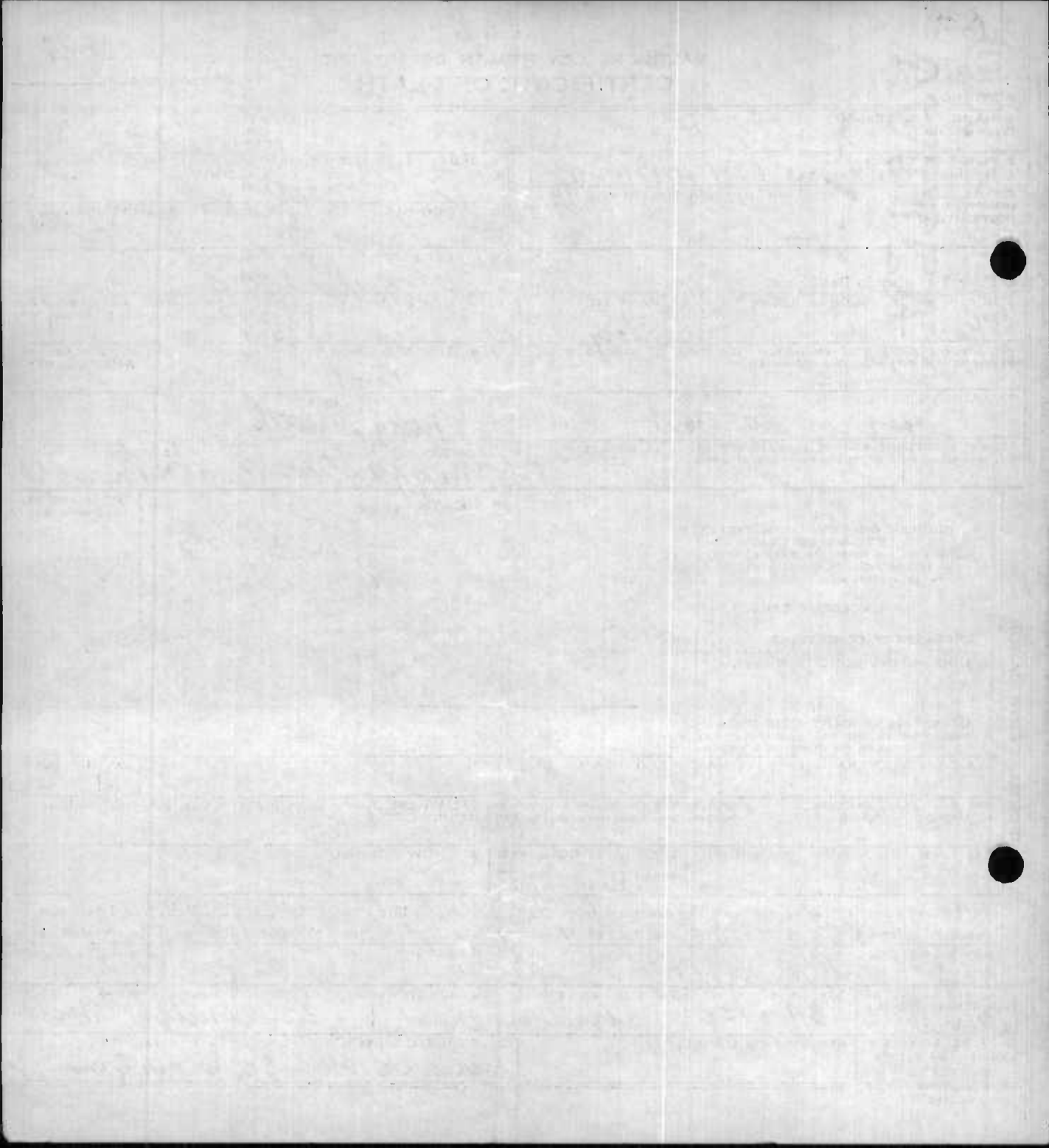
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/4/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Churchyard</i>	24D. LOCATION (City, town, or county) (State) <i>Cambodge MD</i>
---	-------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 2-1950</i>	REGISTRAR'S SIGNATURE _____	25. FUNERAL DIRECTOR <i>Isaiah L. Brown Son</i>	ADDRESS <i>108 W. Montgomery St</i>
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98895

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Webster

50 1828

BIRTH NO. 1828

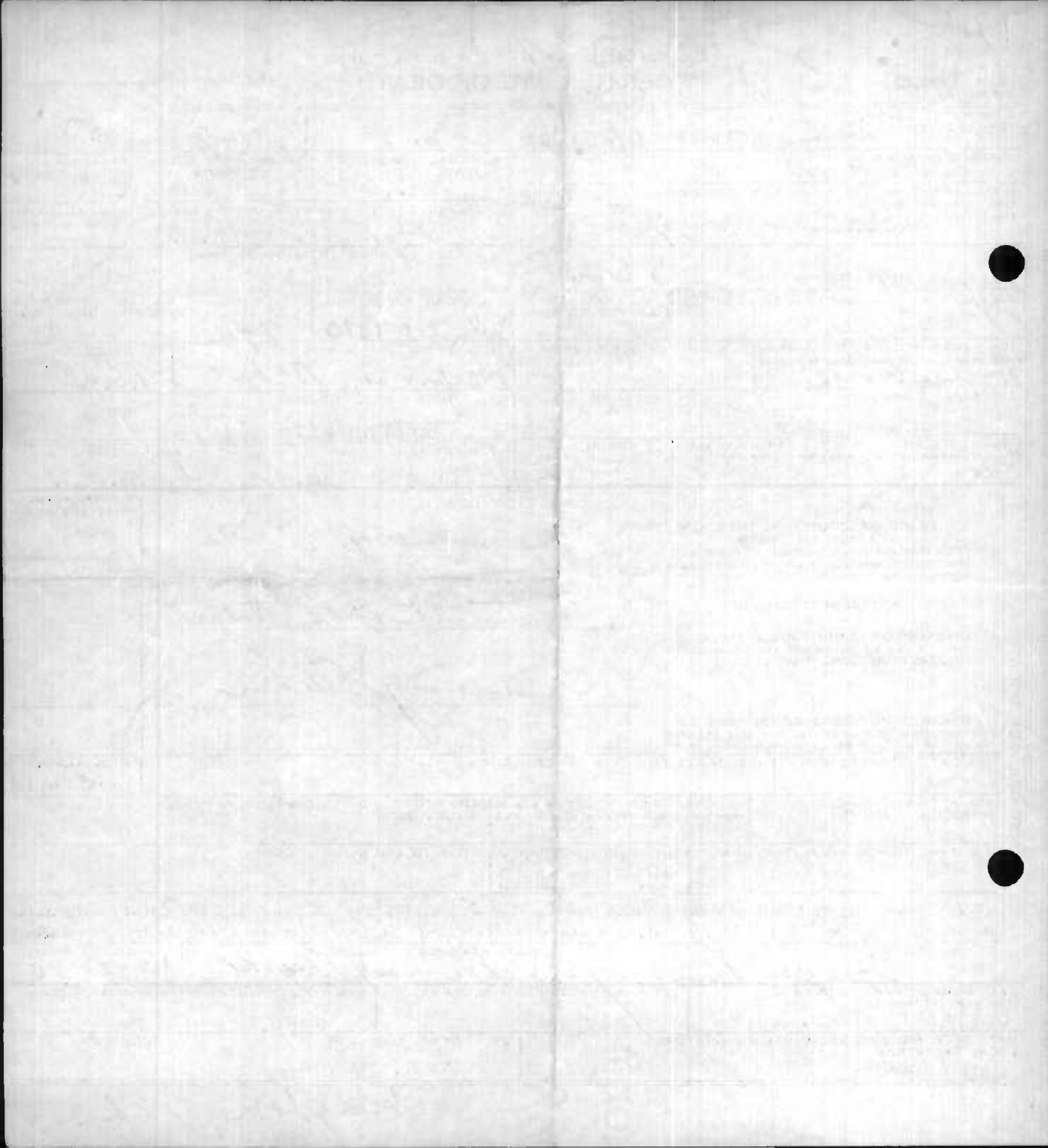
Registered No. _____

1. NAME OF DECEASED (Type or Print) <i>Carrie Webster</i> (Caroline M.)			2. DATE OF DEATH <i>2-28-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Harford</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Bel Air R.D.</i>		
Length of stay in Baltimore <i>6 wks</i>			D. STREET ADDRESS (If rural, give location) <i>Creswell</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>July 30 1870</i>	9. AGE (In years last birthday) <i>79</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <i>Thomas Webster</i>			14. MOTHER'S MAIDEN NAME <i>Susanna Mitchell</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>William Dallam</i>			ADDRESS <i>Bel Air, R.D. Md.</i>		

18. <i>175X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Ovary</i> DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>metastasis to Peritoneum</i> DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pulmonary Edema</i>					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2-28</i> , 19 <i>50</i> , to <i>2-28</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>2-28</i> , 19 <i>50</i> , and that death occurred at <i>5 P</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Joseph H. K... M. D.</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>2-28-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar. 3, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>	
24D. LOCATION (City, town, or county) <i>Calvary, Harford Co., Md</i>		24E. FUNERAL DIRECTOR <i>Howard K. Mc Comas & Son</i>		24F. ADDRESS <i>Abingdon, Md 49a</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 2 - 1950</i>		REGISTRAR'S SIGNATURE <i>...</i>		25. FUNERAL DIRECTOR <i>Howard K. Mc Comas & Son</i>	

MEDICAL CERTIFICATION

correct age as especially important. Physicians: please write the causes of death clearly and legibly.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1829

Registered No. _____

1. NAME OF DECEASED
(Type or Print)

Lucy W. Ball

2. DATE
OF
DEATH

2/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Baltimore, Md.**

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

222 W. Madison Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
222 W. Madison Street

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Isaac L. Ball

8. DATE OF BIRTH

Jan. 17, 1883

9. AGE (in years last birthday)

67

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Frances C. Hedgman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Philip S. Ball Annapolis, Md.

18. **470.1**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

(A) **Coronary Thrombosis**
DUE TO

Stroke

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Arterio-sclerosis**
DUE TO **Myocarditis**
(C) **Hypertension**

Gradual

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 1930**, to **Feb 28, 1950** that I last saw the deceased alive on **Feb 28, 1950**, and that death occurred at **12:50 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

M. H. Hardy

23B. ADDRESS

1403 Park Ave

23C. DATE SIGNED

3/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/3/50

24C. NAME OF CEMETERY OR CREMATORY

Lewinsville Church

24D. LOCATION (City, town, or county)

Lewinsville, Va.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

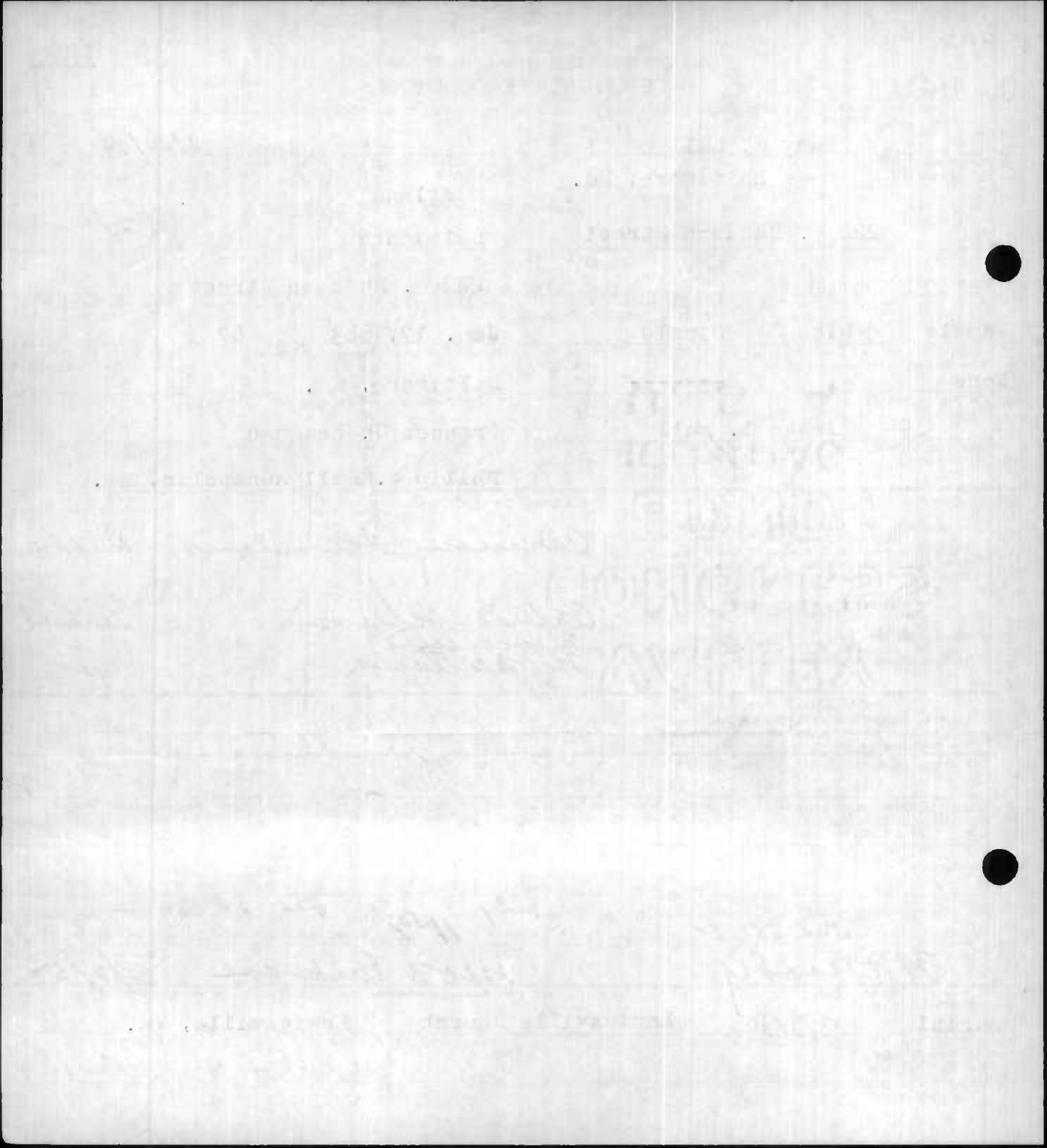
25. FUNERAL DIRECTOR

ADDRESS

MAR 2 - 1950

William H. Hardy

W. W. Meeks and Son 805 N. Calvert St.



B-630

50 1830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1830

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Orris S. Byrd

2. DATE
OF
DEATH

March 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1812 Eutaw Place

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
MarylandB. COUNTY
noneC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1812 Eutaw Place

Length of stay in Baltimore

34 Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

6 - 23 - 1886

9. AGE (In years
last birthday)

63

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

investments

10B. KIND OF BUSINESS OR
INDUSTRY

real estate

11. BIRTHPLACE (State or foreign country)

Withams, Va.

12. CITIZEN OF
WHAT COUNTRY?
U.S.

13. FATHER'S NAME

Johannes L. Byrd

14. MOTHER'S MAIDEN NAME

Elizabeth E. Parks

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.17. INFORMANT
ADDRESS
Richard D. Byrd - 1812 Eutaw Place

18. 4720.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/2, 1950, to 1/2, 1950, that I last saw the
deceased alive on 1/18, 1950, and that death occurred at 12:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Zach. R. Morgan

M. D.

23B. ADDRESS

10 E. Read St., Balto., Md.

23C. DATE SIGNED

3 - 2 - 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

3 - 4 - 50

24C. NAME OF CEMETERY OR CREMATORY

Downing

24D. LOCATION (City, town, or county)

Oak Hall, Va.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl.

MAR 2 - 1950

VS 150

OFFICE USE - In reporting deaths to the State, please indicate the cause of death clearly and legibly.

94a

STATE OF TEXAS
COUNTY OF _____
CERTIFICATE OF DEATH

DATE OF DEATH _____

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

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DECEASED

DECEASED

S-160

50 1831

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1831

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Salome Jane Sparrow

2. DATE
OF
DEATH

2-28-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Hospital for Women of Maryland

Length of stay in Baltimore

33

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 18

12-04

D. STREET ADDRESS (If rural, give location)

2034 N. Calvert St.

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 10, 1864

9. AGE (In years
last birthday)

85

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

West Fairview, Pa.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John Reed

14. MOTHER'S MAIDEN NAME

Susan McLaughlin

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Labor Pneumonia

DUE TO

14 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Generalized Arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 17, 1950, to Feb. 28, 1950, that I last saw the
deceased alive on Feb. 28, 1950, and that death occurred at 10:20 p. m., from the causes and on the date stated above.

23A. SIGNATURE

John R. Smith, Jr.

23B. ADDRESS

M. D. Hosp. for Women of Md. Bldg. Md.

23C. DATE SIGNED

2-28-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

MARCH 3, 1950 LUTHERN-ZION

ENOLA,

PA.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 2 1950

John O. Mitchell & Sons

1900 Eutaw Place

VS 150

108

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

STATE OF NEW YORK
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of burial place		18. Signature of interment		19. Signature of burial place		20. Signature of interment	
21. Signature of burial place		22. Signature of interment		23. Signature of burial place		24. Signature of interment	
25. Signature of burial place		26. Signature of interment		27. Signature of burial place		28. Signature of interment	
29. Signature of burial place		30. Signature of interment		31. Signature of burial place		32. Signature of interment	
33. Signature of burial place		34. Signature of interment		35. Signature of burial place		36. Signature of interment	
37. Signature of burial place		38. Signature of interment		39. Signature of burial place		40. Signature of interment	
41. Signature of burial place		42. Signature of interment		43. Signature of burial place		44. Signature of interment	
45. Signature of burial place		46. Signature of interment		47. Signature of burial place		48. Signature of interment	
49. Signature of burial place		50. Signature of interment		51. Signature of burial place		52. Signature of interment	
53. Signature of burial place		54. Signature of interment		55. Signature of burial place		56. Signature of interment	
57. Signature of burial place		58. Signature of interment		59. Signature of burial place		60. Signature of interment	
61. Signature of burial place		62. Signature of interment		63. Signature of burial place		64. Signature of interment	
65. Signature of burial place		66. Signature of interment		67. Signature of burial place		68. Signature of interment	
69. Signature of burial place		70. Signature of interment		71. Signature of burial place		72. Signature of interment	
73. Signature of burial place		74. Signature of interment		75. Signature of burial place		76. Signature of interment	
77. Signature of burial place		78. Signature of interment		79. Signature of burial place		80. Signature of interment	
81. Signature of burial place		82. Signature of interment		83. Signature of burial place		84. Signature of interment	
85. Signature of burial place		86. Signature of interment		87. Signature of burial place		88. Signature of interment	
89. Signature of burial place		90. Signature of interment		91. Signature of burial place		92. Signature of interment	
93. Signature of burial place		94. Signature of interment		95. Signature of burial place		96. Signature of interment	
97. Signature of burial place		98. Signature of interment		99. Signature of burial place		100. Signature of interment	

B-630

50 1832

Beard

50 1832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Delia Beard

2. DATE
OF
DEATH

Feb 28 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION 1133 W. Cross St.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto.

D. STREET ADDRESS (If rural, give location)

1133 W. Cross St.

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

F.

6. COLOR OR RACE

N

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

Sept. 9, 1878

9. AGE (In years

last birthday)

71 yrs

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of

work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR

INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF

WHAT COUNTRY?

13. FATHER'S NAME

James Finn

14. MOTHER'S MAIDEN NAME

Ann Flaugherty

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

no

(If yes, give war or dates of service)

none

16. SOCIAL

SECURITY NO.

none

17. INFORMANT

ADDRESS

Catherine Kane 2922 Strickland St.

18. 153 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.Coronary Occlusion.
Coronary Atherosclerosis

2-4 hours

27

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐22. I hereby certify that I attended the deceased from Feb 1948, 19, to Feb 28, 1950, that I last saw the
deceased alive on Feb 28, 1950, and that death occurred at 204 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

burial

March 3/50

Holy Cross

Ritchie Hgh. Balto. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Krause Funeral Home 1216S. Charles

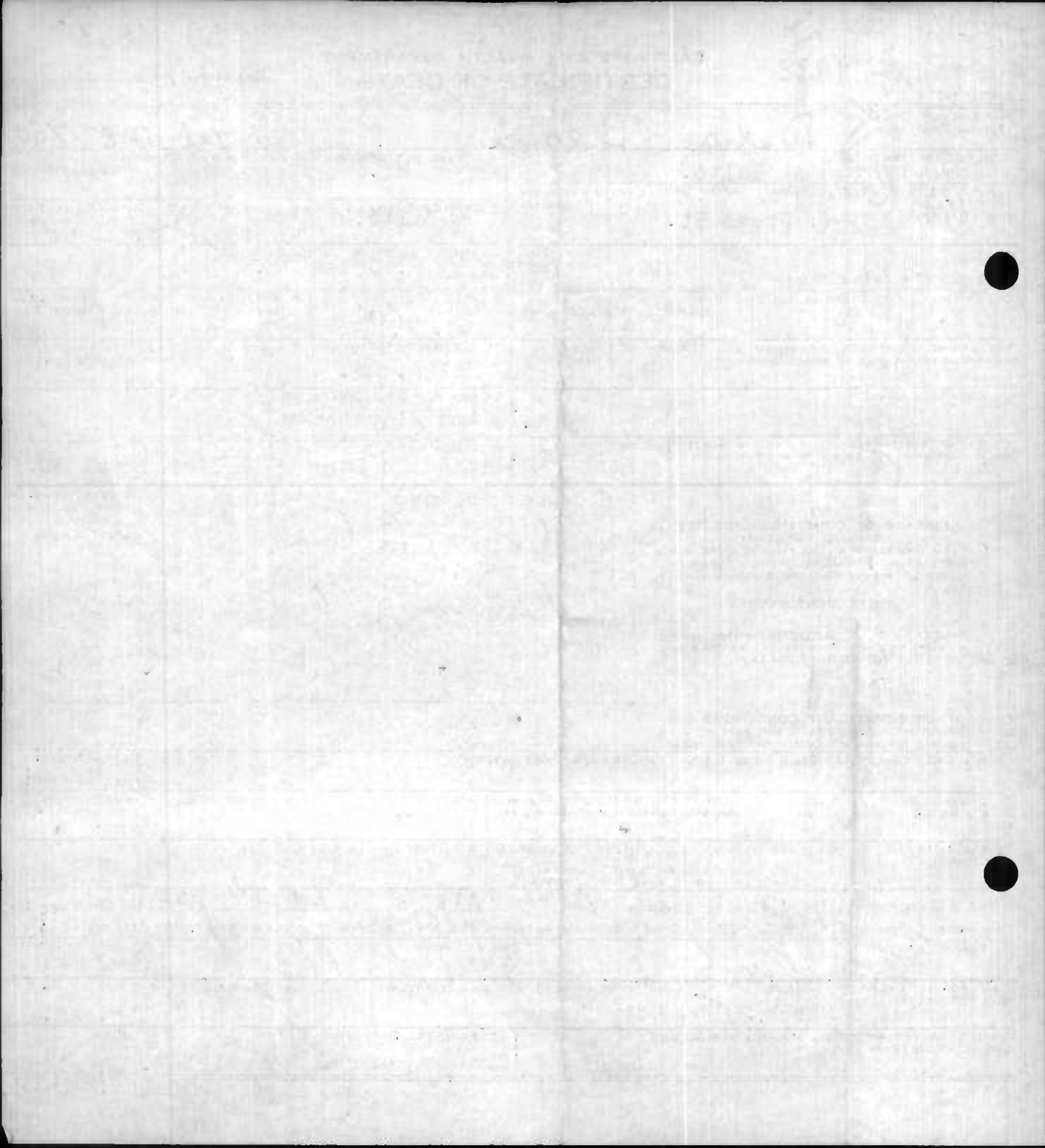
Balto. 30 Md.

MAR 2 - 1950

VS 150

46E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.



330

Sidoti

50 1833

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SAM Sidoti, SAM

2. DATE
OF
DEATH

2/28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

St. AGNES Hospital

Yrs.
Mos.
Days

Length of stay in Baltimore

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

3/11/06

9. AGE (in years
last birthday)

43

If Under 1 Year
Months Days

11 17

If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

SHOE MAKER

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

JAMES Sidoti

14. MOTHER'S MAIDEN NAME

THERESA PROVENZALE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. 540.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Perforated Peptic Ulcer 72 hrs.
with Generalized Peritonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Overwhelming Toxemia

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/27, 1950, to 2/28, 1950, that I last saw the
deceased alive on 2/28, 1950, and that death occurred at 11 1/2 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Stephen H. Padusis

M. D.

23B. ADDRESS

St. Agnes Hospital

23C. DATE SIGNED

2/28/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

March 3-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem 4430 Belair Rd

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

MAR 2 1950

REGISTRAR'S SIGNATURE

William J. Williams

25. FUNERAL DIRECTOR

Frank Della Ucci

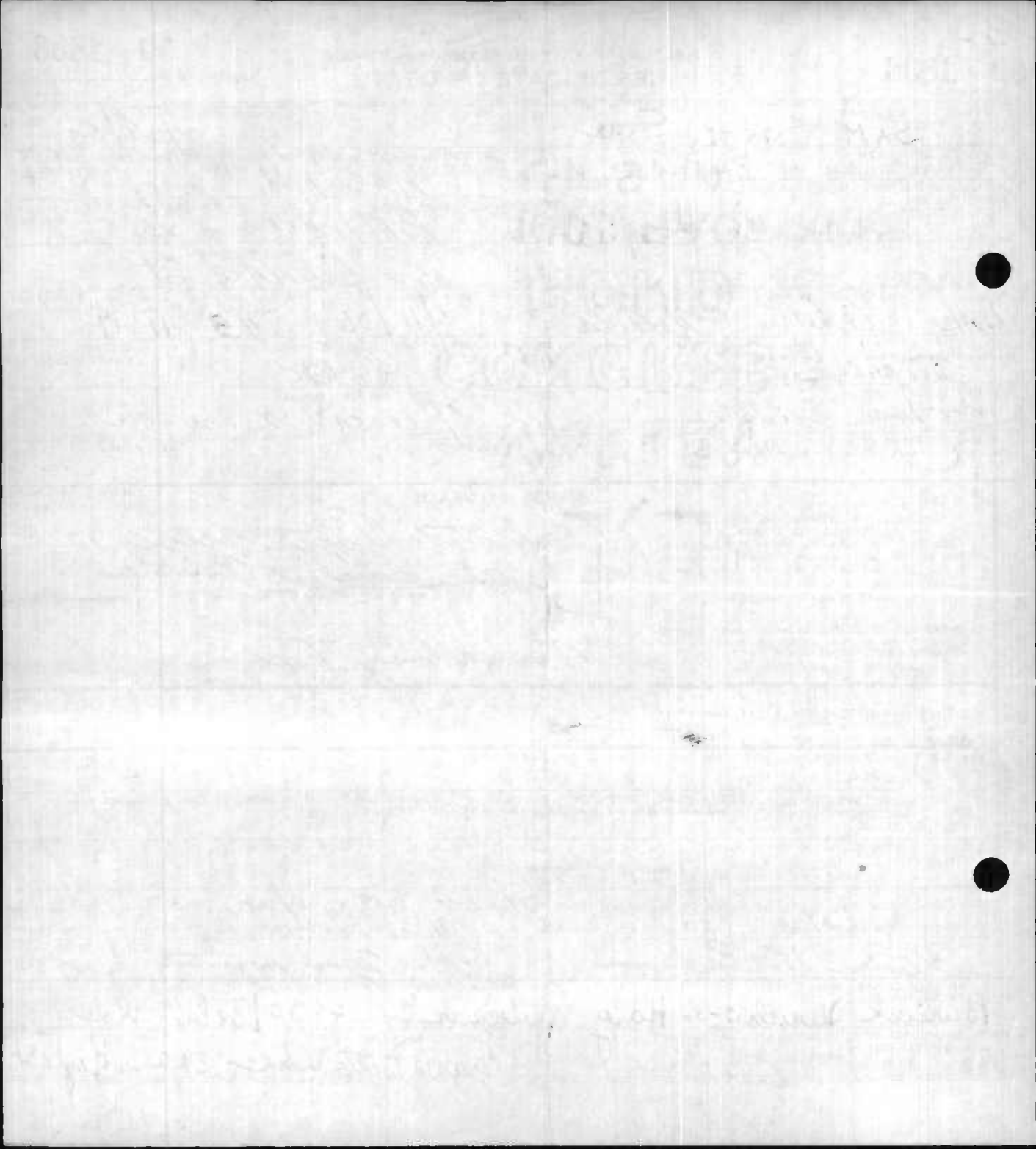
ADDRESS

322 S. High St

VS 150

117a

MEDICAL CERTIFICATION



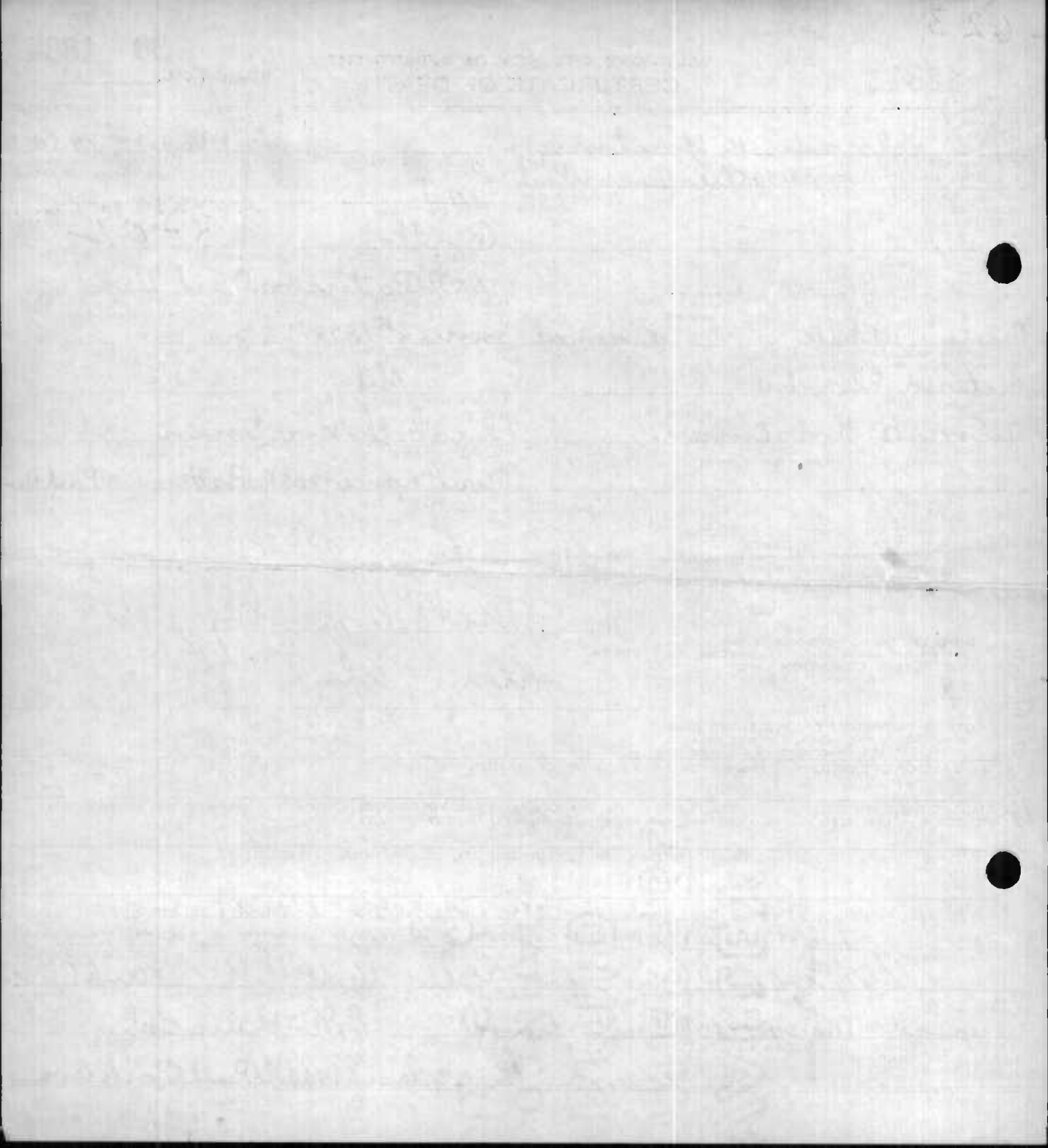
623
50 1834BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1834

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Elonore W. Horstman</i>			2. DATE OF DEATH <i>Mar 1st 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1705 N Patterson Park</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>8-02</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>1705 N Patterson Park Ave</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Jan 28th 1879</i>	9. AGE (In years last birthday) <i>78 yrs</i>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Plumber</i>			11. BIRTHPLACE (State or foreign country) <i>md.</i>		
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <i>Wm. H. Horstman</i>		
14. MOTHER'S MAIDEN NAME <i>Elizabeth Horstman</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>(If yes, give war or dates of service)</i>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <i>Mrs. Leppie 1705 N Patterson Park Ave</i>		
18. <i>177X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CA prostate</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Metastasis - legs, lungs, etc.</i> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>		
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?			22. I hereby certify that I attended the deceased from <i>Oct 1950</i> to <i>March 1, 1950</i> , that I last saw the deceased alive on <i>March 1, 1950</i> , and that death occurred at <i>6 a.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Mrs. Leppie</i>			23B. ADDRESS <i>1431 A Carroll Ave</i>		
23C. DATE SIGNED <i>March 1, 1950</i>			24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		
24B. DATE <i>Mar 4 1950</i>			24C. NAME OF CEMETERY OR CREMATORY <i>Balto Cem</i>		
24D. LOCATION (City, town, or county) (State) <i>E. North Ave Ext</i>			25. FUNERAL DIRECTOR ADDRESS <i>Leo S. Leppie 1703 N Patt Park Ave</i>		



200
50 1835

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1835
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>James M. Wise</i>		2. DATE OF DEATH <i>Feb. 27, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <i>619 S. Rappola St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
6. Length of stay in Baltimore <i>About 28</i>		D. STREET ADDRESS (If rural, give location) <i>619 S. Rappola St.</i>	
7. SEX <i>Male</i>	8. COLOR OR RACE <i>White</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	10. DATE OF BIRTH <i>June 23, 1885</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel Co.</i>	
11. FATHER'S NAME <i>Samuel Wise</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		14. SOCIAL SECURITY NO. <i>213-09-1482</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. MOTHER'S MAIDEN NAME <i>Mary Simon</i>	
17. INFORMANT <i>Mrs. Jennie Wise</i>		18. ADDRESS <i>619 S. Rappola St.</i>	

MEDICAL CERTIFICATION

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Disease</i>		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE <i>Wm. H. Kammer, Jr.</i>	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>	23C. DATE SIGNED <i>Feb. 27, 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3-3-50.</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>
24D. LOCATION (City, town, or county) <i>7225 Eastern Ave. Balto., Md.</i>	24E. DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 2 - 1950</i>	24F. REGISTRAR'S SIGNATURE <i>Charles S. Seiler</i>
24G. DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 2 - 1950</i>	24H. REGISTRAR'S SIGNATURE <i>Charles S. Seiler</i>	24I. FUNERAL DIRECTOR <i>Charles S. Seiler</i>
24J. ADDRESS <i>201 S. Conkling St.</i>		24K. ADDRESS <i>94a</i>

CERTIFICATE OF DEATH



30

0 1836

MARYLAND STATE DEPARTMENT OF HEALTH

50 1836

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Md.		COUNTY		Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		Baltimore		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		Pikesville		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR S. T. ADDRESS		357 S. Drew St.									
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
JULIA		K.		SLADE				March		1 50 19	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year Months. Days Hours Min.	
Female		White		Widowed		6-24-1871		78 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		Retired		House Work Germany U.S.A.	
3. FATHER'S NAME		AUGUST STOLP		14. MOTHER'S MAIDEN NAME		UNKNOWN.					
5. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If year, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT				MRS. EDWARD COMEAU 357 S. DREW ST.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2 weeks	
Immediate cause (a) Heart Failure			
Antecedent cause(s) (b) Pernicious Anemia		years	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
1. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
1. ACCIDENT SUICIDE HOMICIDE		(Specify)	
PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	
INJURY		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF		White at	
INJURY		Not White	
m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

2. I hereby certify that I attended the deceased from Feb 28, 1950, to March 1, 1950, that I last saw the deceased alive on Feb 28, 1950, and that death occurred at 2:45 a.m. from the causes and on the date stated above.

SIGNATURE DATE SIGNED

Louis Daimau M.D. 1413 Reisterstown Rd. Pikesville 8, Md.

1. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
Burial		3-4-50.		Sacred Heart Cemetery		4701 German Hill Rd.		Md	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
MAR 2-1950		Charles J. Gile		901 S. Conkling St., Balto. Md.					

LOUIS DAIMAU, M.D.

73a

IN THE UNITED STATES DISTRICT COURT OF THE DISTRICT OF COLUMBIA

IN RE: THE ESTATE OF JAMES EARL RAY, JR.

FILE NO. 17-10000-00000

IN RE: THE ESTATE OF JAMES EARL RAY, JR.

FILE NO. 17-10000-00000

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FILE NO. 17-10000-00000

IN RE: THE ESTATE OF JAMES EARL RAY, JR.

FILE NO. 17-10000-00000

IN RE: THE ESTATE OF JAMES EARL RAY, JR.

FILE NO. 17-10000-00000

163

Hubert

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1837

50 1837

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John J. Hubert</i>		2. DATE OF DEATH <i>Feb. 28, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2528 E. Preston St</i>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>80</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 8-03</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2528 E. Preston St</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>June 9, 1864</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Balto Iron Co.</i>	
11. FATHER'S NAME <i>Carl J. Hubert</i>		12. CITIZEN OF WHAT COUNTRY?	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		14. MOTHER'S MAIDEN NAME <i>Catherine Elcasser</i>	
15. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Barbara Hubert-2528 E. Preston St</i>		ADDRESS	

18. <i>450.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Nephritis</i>	CAUSE OF DEATH (A) <i>Chronic Nephritis</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Arteriosclerosis</i>	(B) <i>Arteriosclerosis</i> DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Uremia</i>	(C) <i>Uremia</i>	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan. 24, 1950*, to *Feb. 28, 1950*, that I last saw the deceased alive on *Feb. 28, 1950*, and that death occurred at *11:47 P.M.*, from the causes and on the date stated above.

23A. SIGNATURE *Joseph J. Jansky* M.D. 23B. ADDRESS *441 S. Ellwood Ave* 23C. DATE SIGNED *3/1/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *3-4-50* 24C. NAME OF CEMETERY OR CREMATORY *Parkwood Cem* 24D. LOCATION (City, town, or county) (State) *Taylor Ave. Balto. Md*

DATE RECEIVED BY LOCAL REGISTRAR *MAR 2 - 1950* REGISTRAR'S SIGNATURE *John C. Milly* 25. FUNERAL DIRECTOR *John C. Milly* ADDRESS *2435 E. Olney St*

441 5 LILWOOD

346
50 1838

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1838
Registered No.

BIRTH NO.

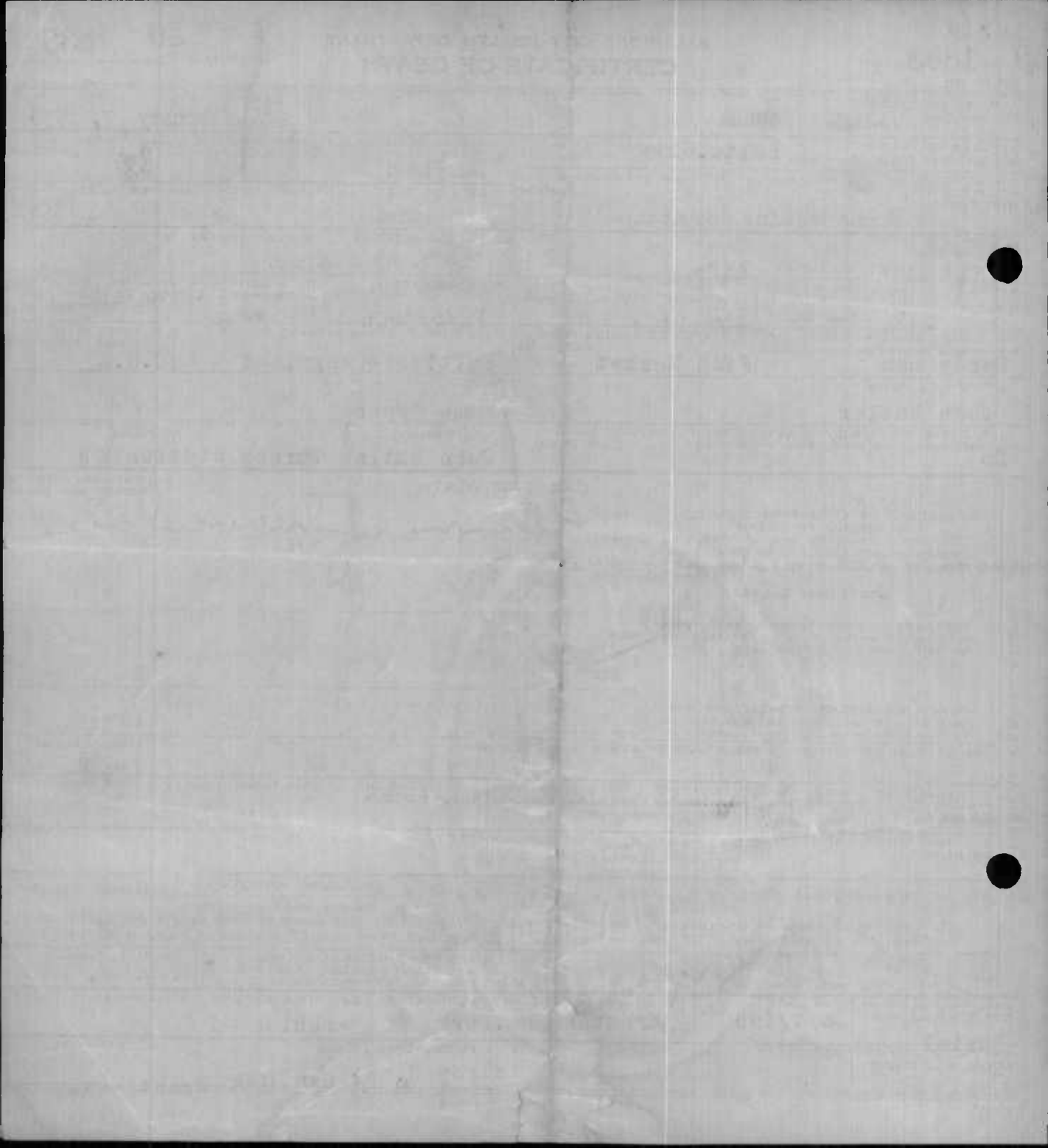
1. NAME OF DECEASED (Type or Print) ALBERT BUTLER		2. DATE OF DEATH February 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 109 S. Bond Street		E. LENGTH OF STAY IN BALTIMORE Life	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12/5/1906
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handy man		10B. KIND OF BUSINESS OR INDUSTRY Fish Market	9. AGE (In years last birthday) 43
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Emma Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT John Butler Turner Station Md		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 002X I		CAUSE OF DEATH Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>partial autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE Carl R. Boyer		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D.		23C. DATE SIGNED Feb. 28, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/4/1950		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) (State) Arbutus Md		24E. LOCATION (City, town, or county) (State) Arbutus Md		24F. LOCATION (City, town, or county) (State) Arbutus Md	

DATE RECEIVED BY LOCAL REGISTRAR MAR 2 - 1950		REGISTRAR'S SIGNATURE Elroy O. Wilson		25. FUNERAL DIRECTOR Elroy O. Wilson 1000 Brantly Ave	
VS 151				1313	

correct age is especially important. In extensions, please write the cause of death clearly and legibly.



620

BURCK.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1839

Registered No. _____

50 1839

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Elizabeth Young Burck</i>		2. DATE OF DEATH <i>March 1, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>18-02</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Maryland General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>423 North Carey St.</i>			
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			
5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 13, 1863</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HSW</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (In years last birthday) <i>86</i>
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Ruhl</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>no.</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mr. Harvey H. Ruhl</i>		ADDRESS <i>Phila., Pa. 148 Washington Lane</i>	

18. *561.4*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *generalized emaciation*
DUE TO*5 months*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Hiatus Hernia*
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Diabetes Mellitus & generalized arteriosclerosis*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐22. I hereby certify that I attended the deceased from *Dec 6*, 19*50*, to *March 1*, 19*50*, that I last saw the deceased alive on *March 1*, 19*50*, and that death occurred at *10:25 pm.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*MAR 2 - 1950**WM. J. TICKNER & SONS**Balto., Md.*

216

McBRIDE
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1840

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James L. G. McBride

2. DATE
OF
DEATH

Feb 28/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2026 Fairmount

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE Md B. COUNTY before admission)

C. CITY OR TOWN

(If outside corporate limits, write LOCAL and give township)

D. STREET ADDRESS (If rural, give location)

2026 E Fairmount Ave

C. Length of stay in Baltimore

60

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan 21/1880

9. AGE (In years
last birthday)

70

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Ship yard

10B. KIND OF BUSINESS OR
INDUSTRY

Beck Steel

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Cles Helick 2026 Fairmount Ave

18. 610.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Acute suppression of kidneys

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Cardio-vascular failure

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Prostatectomy - 2 mos ago
Hypertension - 10 years at Sueding Institute

19A. DATE OF OPERATION

1.5.50

19B. MAJOR FINDINGS OF OPERATION

Benign prostatic hypertrophy

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from Feb 28, 1950, to Feb 28, 1950, that I last saw the
deceased alive on Feb 28, 1950, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Bryant M. Jaffe

M. D.

23B. ADDRESS

2028 E Fairmount Ave

23C. DATE SIGNED

Feb 1.50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Mar 4/50

24C. NAME OF CEMETERY OR CREMATORY

Balt. Cem

24D. LOCATION (City, town, or county)

Balt

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Bryant M. Jaffe

25. FUNERAL DIRECTOR

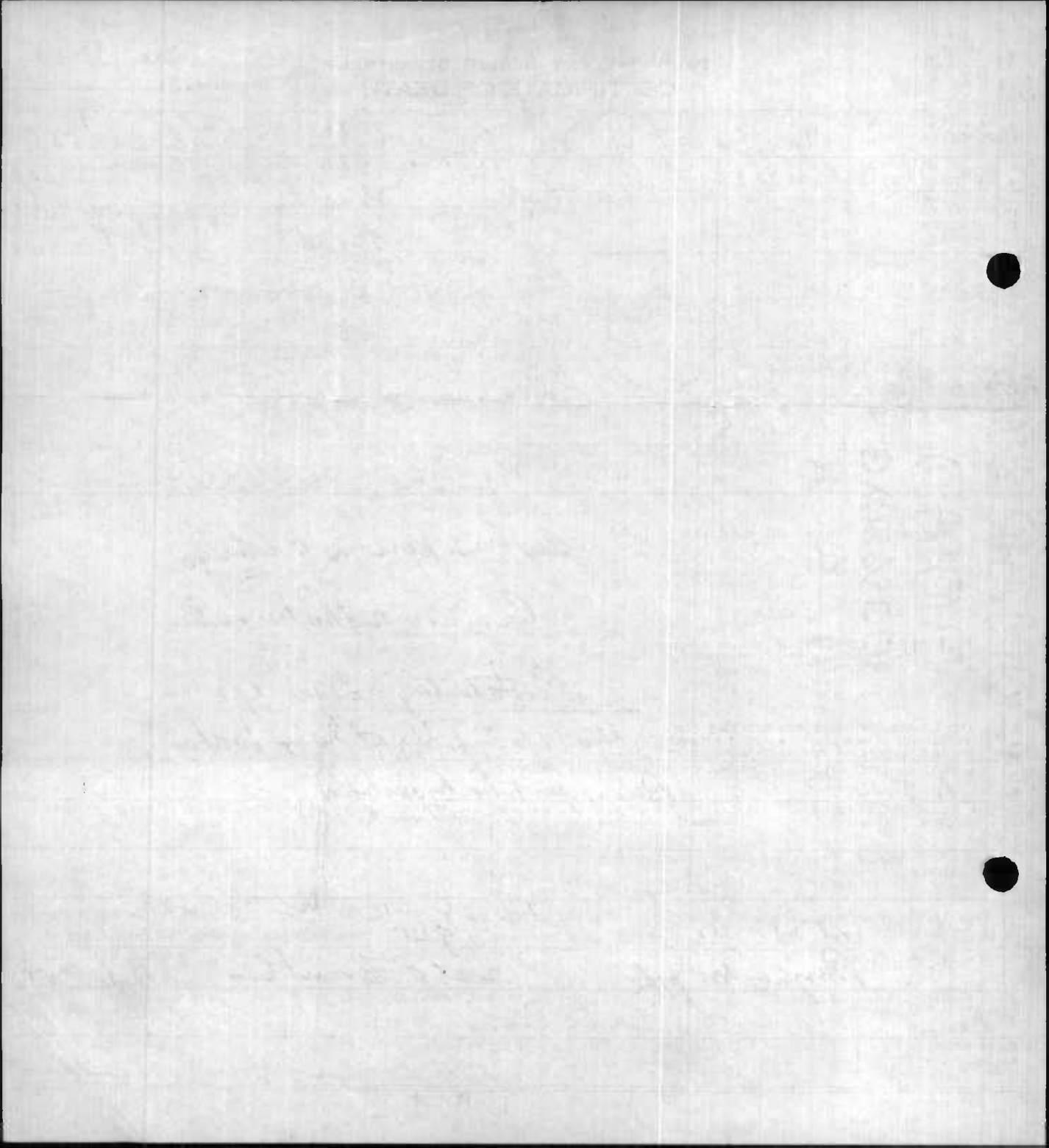
ADDRESS

Ullrich Funeral Home 2008 Alameda

MAR 2 - 1950

1840 1840 1840 1840

MEDICAL CERTIFICATION



635
50 1841KURDNA
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1841

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Frances Kurdna

2. DATE
OF
DEATH

Feb. 28, 1950

3. PLACE OF DEATH:
A. Baltimore City, MarylandB. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution; residence
A. STATE B. COUNTY before admission)

Md

C. CITY OR TOWN (If outside corporate limits, write SURNAME and give
township)

Baltimore 7-030

D. STREET ADDRESS (If rural, give location)

711 N. Lakewood Ave

5. Length of stay in Baltimore

Yrs.
Mos.
Days

6. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

12-28-75

9. AGE (In years
last birthday)

75

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH.
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

Ant. Myocardial Infarction 5d.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

Hypertensive +

arterio sclerotic C.V.
disease

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.Hypostatic
lobular pneumonia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/25, 1948, to 2/28, 1948, that I last saw the
deceased alive on 2/28, 1948, and that death occurred at 7:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Steven Berkus

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Mar 3/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Balto

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

ADDRESS

Ulrich Funeral Home 2008 Calver

CERTIFICATE OF DEATH

State of New York, County of _____

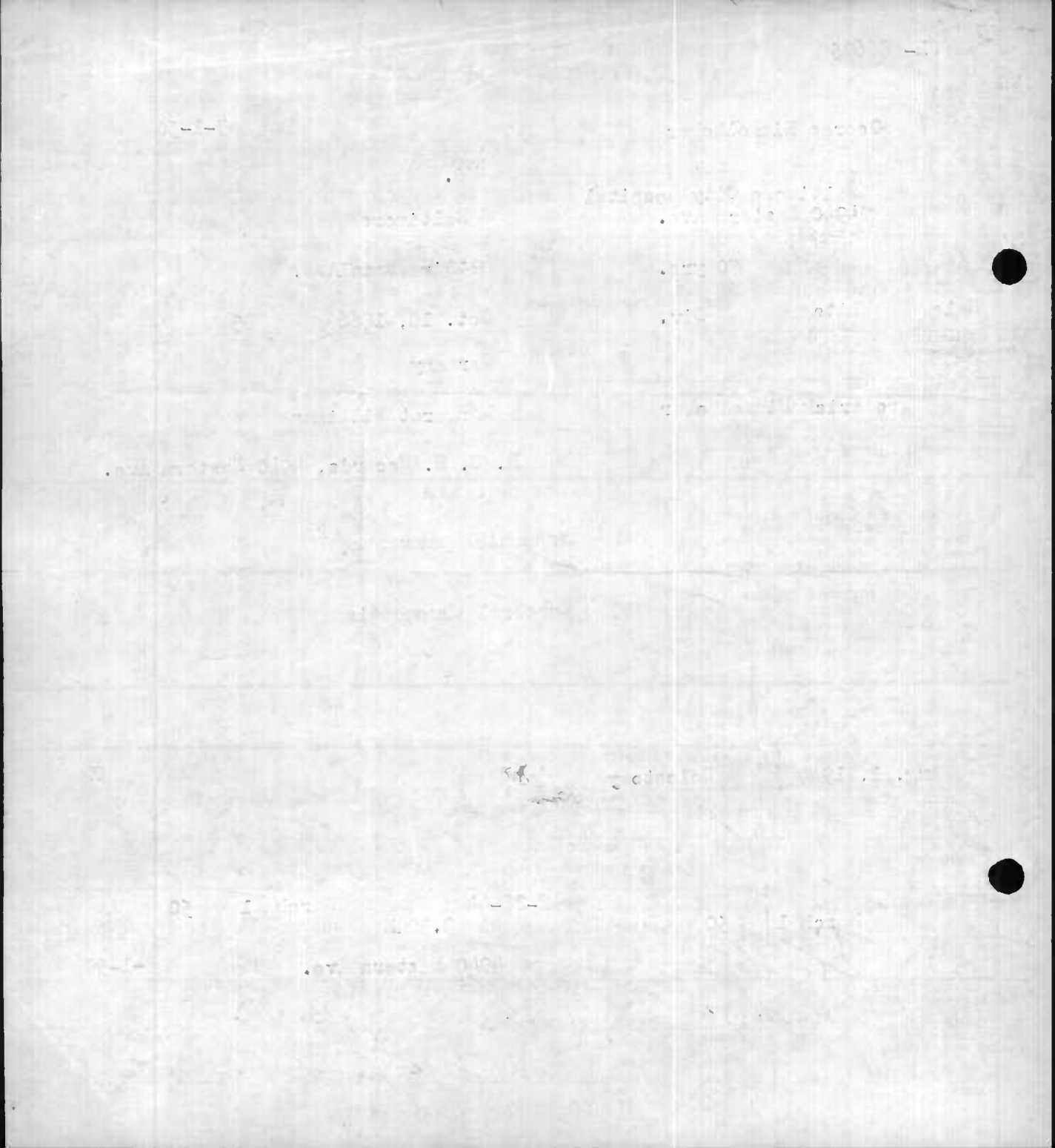
On this _____ day of _____ 19____

at _____ in the City of _____

_____ died _____

at the age of _____ years

BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
CERTIFICATE OF DEATH		50 1842	
BIRTH NO.		541	
1. NAME OF DECEASED (Type or Print) George Himmelheber		2. DATE OF DEATH 3-1-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 4940 Eastern Ave.		E. LENGTH OF STAY IN BALTIMORE 70 yrs.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Div.	8. DATE OF BIRTH Oct. 10, 1866
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 83
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Himmelhaber		14. MOTHER'S MAIDEN NAME Margaret Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT B. C. H. Records, 4940 Eastern Ave.		ADDRESS	
18. 332. X CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) Bronchial pneumonia DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Cerebral thrombosis DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION Aug. 1, 1944		19B. MAJOR FINDINGS OF OPERATION Colostomy	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from 2-28-44 , 19 44 , to March 1 , 19 50 , that I last saw the deceased alive on March 1 , 19 50 , and that death occurred at 3.30AM , from the causes and on the date stated above.	
23A. SIGNATURE [Signature]		23B. ADDRESS 4940 Eastern Ave.	
23C. DATE SIGNED 3-1-50		24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24B. DATE Mar 4 1950		24C. NAME OF CEMETERY OR CREMATORY Lorraine	
24D. LOCATION (City, town, or county) (State) Balt		25. FUNERAL DIRECTOR Ullrich Funeral Home	
26. DATE RECEIVED BY LOCAL REGISTRAR MAR 2 - 1950		27. REGISTRAR'S SIGNATURE [Signature]	
28. VS 150		29. 195000001844	
30. 83B			



460
MS-136148
50 1843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1843
Registered No.

BIRTH NO. 50-04044

1. NAME OF DECEASED (Type or Print) Baby Girl "B" Miller--Vildeatha		2. DATE OF DEATH 2-28-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-05	
D. STREET ADDRESS (If rural, give location) 311 E. Lafayette Ave.		5. SEX Female	
6. COLOR OR RACE Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. DATE OF BIRTH 2-27-50		9. AGE (In years last birthday) 1	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Miller		14. MOTHER'S MAIDEN NAME Vildeatha Christina Speed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Baltimore City Hospitals		ADDRESS Records--4940 Eastern Ave.	

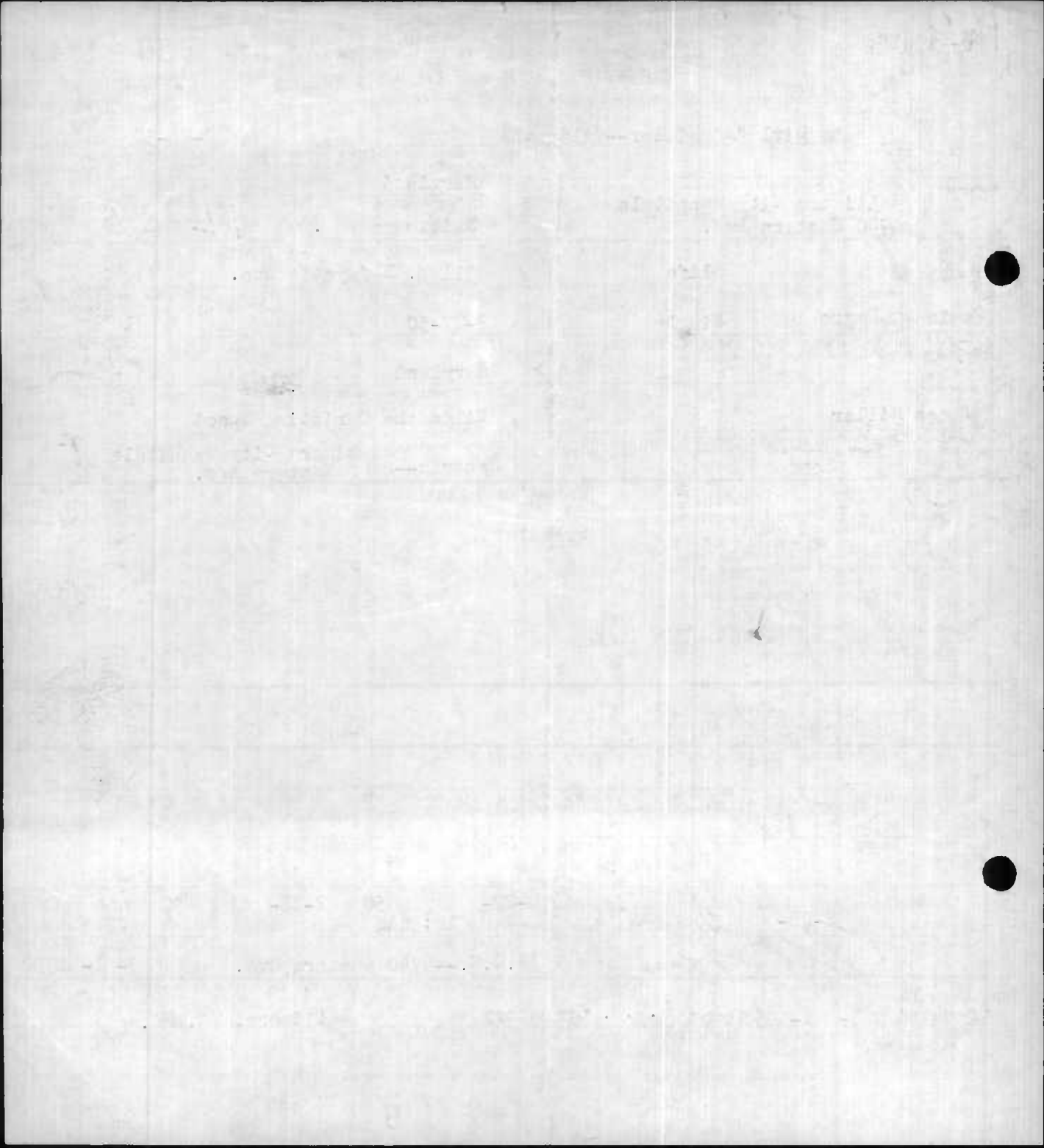
18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Prematurity (A) Prematurity DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) 		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2-27-**, 19 **50** to **2-28-**, 19 **50** that I last saw the deceased alive on **2-28-**, 19 **50**, and that death occurred at **10:30AM**, from the causes and on the date stated above.

23A. SIGNATURE **[Signature]** M. O. **B.C.H.--4940 Eastern Ave.** 23B. ADDRESS **3-1-1950** 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated		24B. DATE 3-1-1950 at 9.00AM		24C. NAME OF CEMETERY OR CREMATORY B.C.H. Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, 24, Md.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 2-1950		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR		ADDRESS	



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 1844

Registered No. _____

520
1844
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Vanik, James Frank		2. DATE OF DEATH March 1, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Md. b. COUNTY Balti	
b. FULL NAME OF HOSPITAL OR WISCONSIN St. Joseph's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) 5th Ave. & Harford Rd.	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 27, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher - Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Meat	9. AGE (In years last birthday) 57
13. FATHER'S NAME John Vanik		11. BIRTHPLACE (State or foreign country) Balto., Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? USA	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Frances Kuffel	
17. INFORMANT		ADDRESS Mrs. J. F. Vanik, 5th Ave., Balto., 14, Md.	

18. 4/20.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac decompensation (A) arteriosclerotic heart disease DUE TO		CAUSE OF DEATH Diffuse pneumonitis (B) _____ DUE TO	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from February 24, 1950 to March 1, 1950 that I last saw the deceased alive on March 1, 1950 , and that death occurred at 6:20p. m. , from the causes and on the date stated above.			
23A. SIGNATURE Maddeus Siivinski		23B. ADDRESS 1100 N. Caroline St.	
23C. DATE SIGNED March 1, 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE Mar. 4, 1950	24C. NAME OF CEMETERY OR CREMATORY Parkwood	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR L. [Signature]	
		ADDRESS 7401 Belair Rd.	

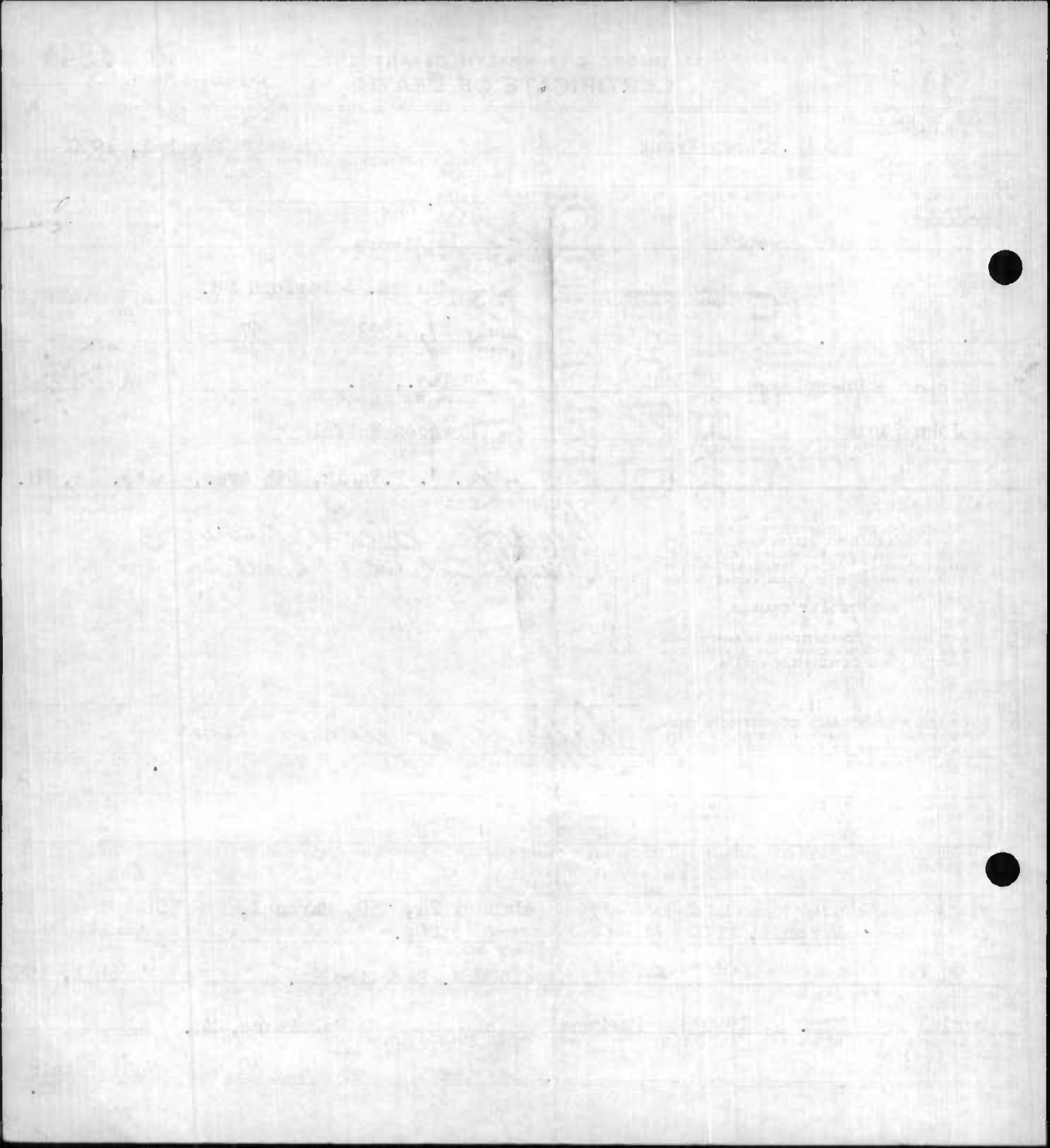
MAR 2 1950

45261

937

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1845
Registered No.

50 1845

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CONRAD H. LUNZ		2. DATE OF DEATH March 1st, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION 6301 Brook Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 27-05	
Length of stay in Baltimore life Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 6301 Brook Avenue	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 24th, 1873
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leather Worker		10B. KIND OF BUSINESS OR INDUSTRY Leather Co.	9. AGE (In years last birthday) 76 If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME T. William Lunz		14. MOTHER'S MAIDEN NAME Mary Kahl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-07-2976	
17. INFORMANT Mrs. C. H. Lunz, 6301 Brook Ave., Balto. 6, Md.		ADDRESS _____	

18. 443. X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocarditis (A) _____ DUE TO _____	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH 5 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Ch Myocarditis DUE TO _____ (C) Ch Hypertension. Arteriosclerosis		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **2/25**, 19**50**, to **3/1**, 19**50**, that I last saw the deceased alive on **2/28**, 19**50**, and that death occurred at **9:30** m., from the causes and on the date stated above.

23A. SIGNATURE J. H. Hanning		23B. ADDRESS 3805 Belair Rd		23C. DATE SIGNED 3/1/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) burial		24B. DATE Mar. 4, 1950		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Rd	

correct age is especially important. Physicians, please write the causes of death clearly and legibly.

STATE OF NEW YORK
CERTIFICATE OF DEATH

10



655

1846

HARMON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

1846

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bernard E. Harmon

2. DATE
OF
DEATH

March 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1730 Webster St

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Brooklyn

D. STREET ADDRESS (If rural, give location)

930 Victory Ave

Length of stay in Baltimore

20

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 13, 1899

9. AGE (In years,
last birthday)

50

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Bus. Foreman

10B. KIND OF BUSINESS OR
INDUSTRY

B.T.O.R.R.

11. BIRTHPLACE (State or foreign country)

Saint Marie Ill

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Charles Harmon

14. MOTHER'S MARRIED NAME

Arbella Cox

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes 1-18 World

16. SOCIAL
SECURITY NO.

705-05-8875

17. INFORMANT

Ewell E. Harmon

ADDRESS

930 Victory Rd

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Coronary occlusion

4 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(B) Chronic coronary sclerosis

7 yrs

(C) Generalized arteriosclerosis -

10+ yrs

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial infarction

7 yrs ago

19A. DATE OF OPERATION

no

19B. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

no

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

no

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1, 1950, to 3/1, 1950, that I last saw the
deceased alive on 3/1, 1950, and that death occurred at 0.15 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Maurice Feldman Jr.

23B. ADDRESS

817 St Paul St.

23C. DATE SIGNED

3/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

March 3, 1950

24C. NAME OF CEMETERY OR CREMATORY

?

24D. LOCATION (City, town, or county)

Philadelphia, Pa.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 2 - 1950

A. Harold Evans 1400 S. St. Louis

VS 150

496 47 Bal Co. 30, Md. 94a

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO
LIBRARY OF THE DIVISION OF THE PHYSICAL SCIENCES

DAISY I. RUARK
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1847

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print) *Daisy I. Ruark*

2. DATE OF DEATH *2/28/50*

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE *Md* B. COUNTY _____

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION *University Hospital Baltimore*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 20-03

D. STREET ADDRESS (If rural, give location)
2005 Christian St.

5. SEX *F* 6. COLOR OR RACE *W* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH *4-15-85* 9. AGE (In years last birthday) *64* 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
H.W. 10B. KIND OF BUSINESS OR INDUSTRY *Own home*

11. BIRTHPLACE (State or foreign country) *Md* 12. CITIZEN OF WHAT COUNTRY? _____

13. FATHER'S NAME *Simon*

14. MOTHER'S MAIDEN NAME *Unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. _____

17. INFORMANT ADDRESS
Christie Ruark, 2005 Christian St.

18. *157. X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Generalized carcinomatosis*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Carcinoma pancreas*

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Pulmonary edema, cardiac decomp.*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2/14*, 1950, to *2/28*, 1950, that I last saw the deceased alive on *2/28*, 1950, and that death occurred at *10³⁰ P. M.*, from the causes and on the date stated above.

23A. SIGNATURE *Ed C. McClumb*

M. D.

23B. ADDRESS *University Hosp.*

23C. DATE SIGNED *3/1/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*

24B. DATE *3/4/50*

24C. NAME OF CEMETERY OR CREMATORY *Glen Haven*

24D. LOCATION (City, town, or county) (State) *Glen Burnie, Md*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE *Wm. H. Williams*

25. FUNERAL DIRECTOR

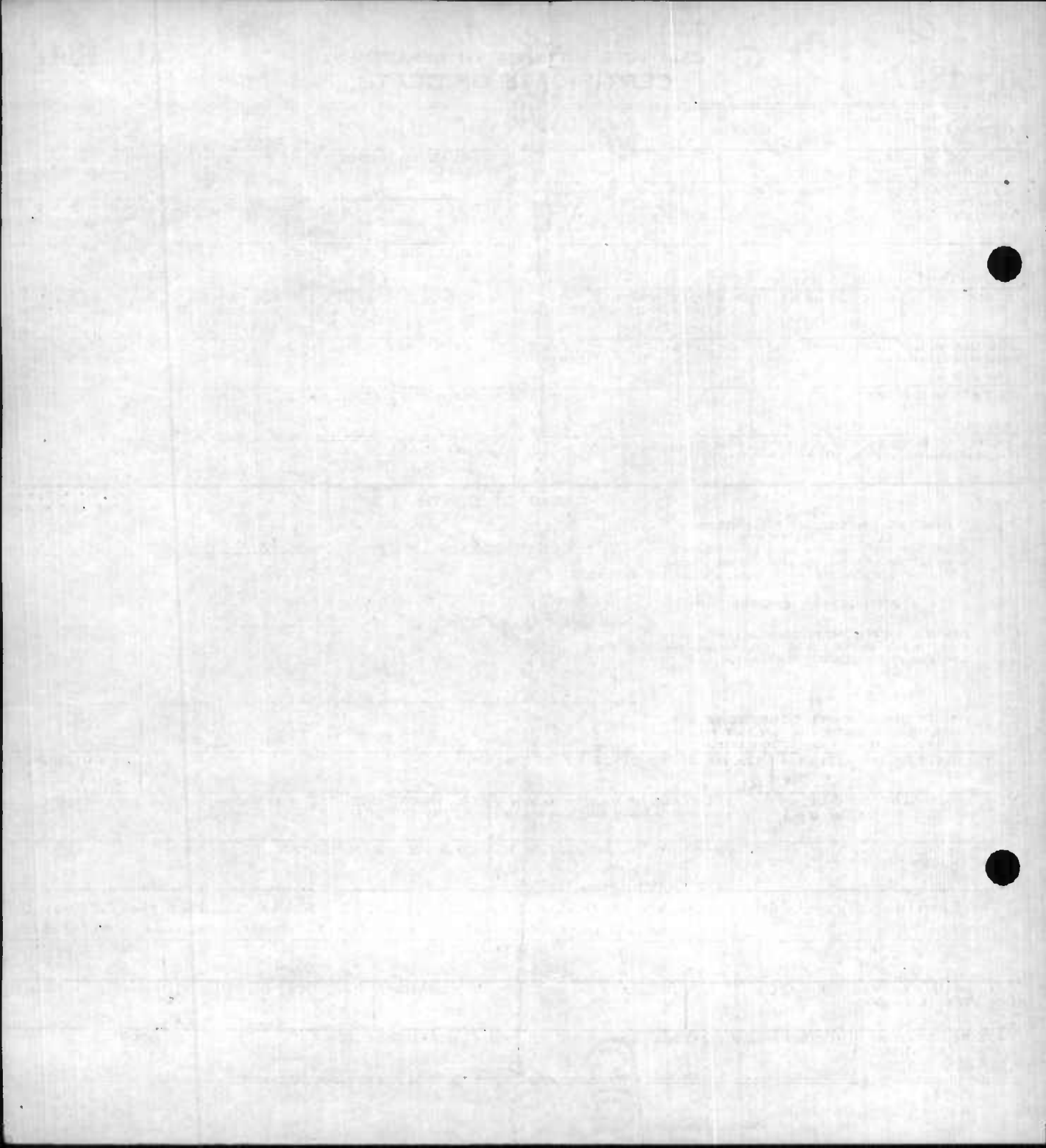
ADDRESS

MAR 2 - 1950

Harry H. Dwyer, 4101 Edmondson

correct age is especially important. Informants, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1848
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Patrick Joseph Gary

2. DATE
OF
DEATH

2/28/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland **Baltimore City**

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)
3718 Edmondson Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore City **16-08**

D. STREET ADDRESS (If rural, give location)
3718 Edmondson Ave.

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

Single

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Building

13. FATHER'S NAME

Charles L. Gary

8. DATE OF BIRTH

9/12/1900

9. AGE (In years last birthday)

49

If Under 1 Year Months Days If Under 24 Hours Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Catherine C. Keelty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mary A. Conneran 3718 Edmondson Ave

18. **151X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinoma of the Stomach

INTERVAL BETWEEN ONSET AND DEATH

6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

Oct, 1949

19B. MAJOR FINDINGS OF OPERATION

Inoperable Carcinoma of the stomach

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec**, 19**50**, to **Feb 28**, 19**50** that I last saw the deceased alive on **Feb 23**, 19**50**. and that death occurred at **1:30 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE

William F Pearce

M. D.

23B. ADDRESS

2105 N Charles St

23C. DATE SIGNED

Mar 1, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/3/1950

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town or county) (State)

Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR

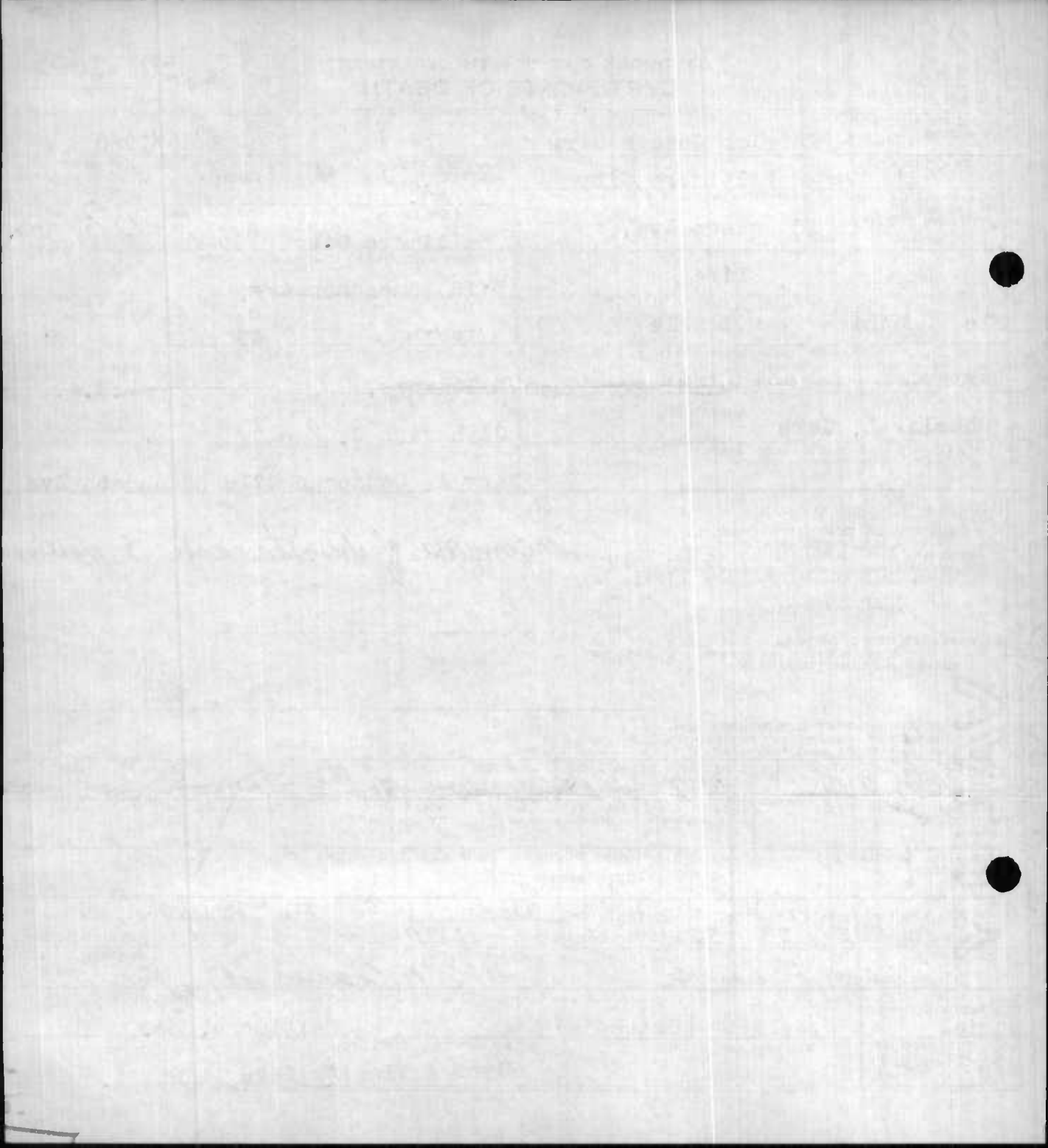
MAR 2 - 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Flynn & Fleming 1426 Light St.



524

1849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1849

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charlotte Hensley

2. DATE
OF
DEATH

March 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY before admission)

Md. Baltimore

5. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Hanover

D. STREET ADDRESS (If rural, give location)

Ridge Rd. 5300

6. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

6-15-144

9. AGE (In years
last birthday)

3 1/2

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

a.a.c. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Raymond E. Hensley

14. MOTHER'S MAIDEN NAME

Josephine M. Lloyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 193X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Medullary Compression

2 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Tumor hypothalamus
malignant3 mos.
over

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

28 Feb 50

19B. MAJOR FINDINGS OF OPERATION

Increased intracranial pressure.

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/21, 1950, to 3/1, 1950, that I last saw the
deceased alive on 3/1, 1950, and that death occurred at 12 m., from the causes and on the date stated above.

23A. SIGNATURE

Robert J. Fisher

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

2 Mar 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/4/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 3 - 1950

Wm Cook Inc. 1217 St. Paul St.

VS 150

542

MEDICAL CERTIFICATION

Correct age is especially important. In physicians, please write the cause of death clearly and briefly.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Letter in document file 50-1849 4/10/50.

426
50 1850BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1850
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) REUBEN ALGER		2. DATE OF DEATH 3-1-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE MARYLAND B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-04			
Length of stay in Baltimore 64 yrs.		D. STREET ADDRESS (If rural, give location) 2526 McHENRY ST.			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH MARCH 12, 1884	9. AGE (In years, last birthday) 65	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Retired Railroad		11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME MARTIN ALGER		14. MOTHER'S MAIDEN NAME Unknown.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) No.		16. SOCIAL SECURITY NO. 705-05-3632		17. INFORMANT ADDRESS Mrs. R. C. Sutor 2503 Arbuton Ave	
18. J92X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Uremia DUE TO ANTECEDENT CAUSES Chronic Glomerulonephritis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Purpura following sulfonamide therapy Eczematoid Dermatitis					INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-14- 1950, to 3-1- 1950, that I last saw the deceased alive on 3-1- 1950, and that death occurred at 9 P. m., from the causes and on the date stated above.					
23A. SIGNATURE W. A. Wetnam M. D.		23B. ADDRESS University Hospital		23C. DATE SIGNED 3-1-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3-4-50		24C. NAME OF CEMETERY OR CREMATORY PLEASANT VIEW	
24D. LOCATION (City, town, or county) (State) FREDERICK County Md.		25. FUNERAL DIRECTOR ADDRESS GEO. L. Schwab 2101 Frederick Ave.			
DATE RECEIVED BY LOCAL REGISTRAR MAR 3-1950		REGISTRAR'S SIGNATURE W. A. Wetnam		25. FUNERAL DIRECTOR ADDRESS GEO. L. Schwab 2101 Frederick Ave.	

RECEIVED

NOV 1961

NOV 1961

NOV 1961

NOV 1961

NOV 1961

NOV 1961

NOV 1961

NOV 1961

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Katherine E. Huebscher

2. DATE
OF
DEATH

MARCH 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1927 RAMSAY ST

C. Length of stay in Baltimore

LIFE

Yrs.
Mos.
Days

5. SEX

FEMALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Sept. 6, 1866

9. AGE (In years
last birthday)

83

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of worklog life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY EMERICK

14. MOTHER'S MAIDEN NAME

Wilhelmina Hidey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

None

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

EMMA HUEBSCHER 1927 RAMSAY ST

18. 450.0

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

GENERALIZED ARTERIOSCLEROSIS
85 YRS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/9/48, 19, to FEBRUARY 1, 1950, that I last saw the deceased alive on FEB 28, 1950, and that death occurred at 5:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

Robert H. Katz

M. D.

23B. ADDRESS

2675 WILKENS AVE

23C. DATE SIGNED

MARCH 1, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

MARCH 4, 1950

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county)

BALTIMORE, Maryland.

DATE RECEIVED BY
LOCAL REGISTRAR

MAR 3 - 1950

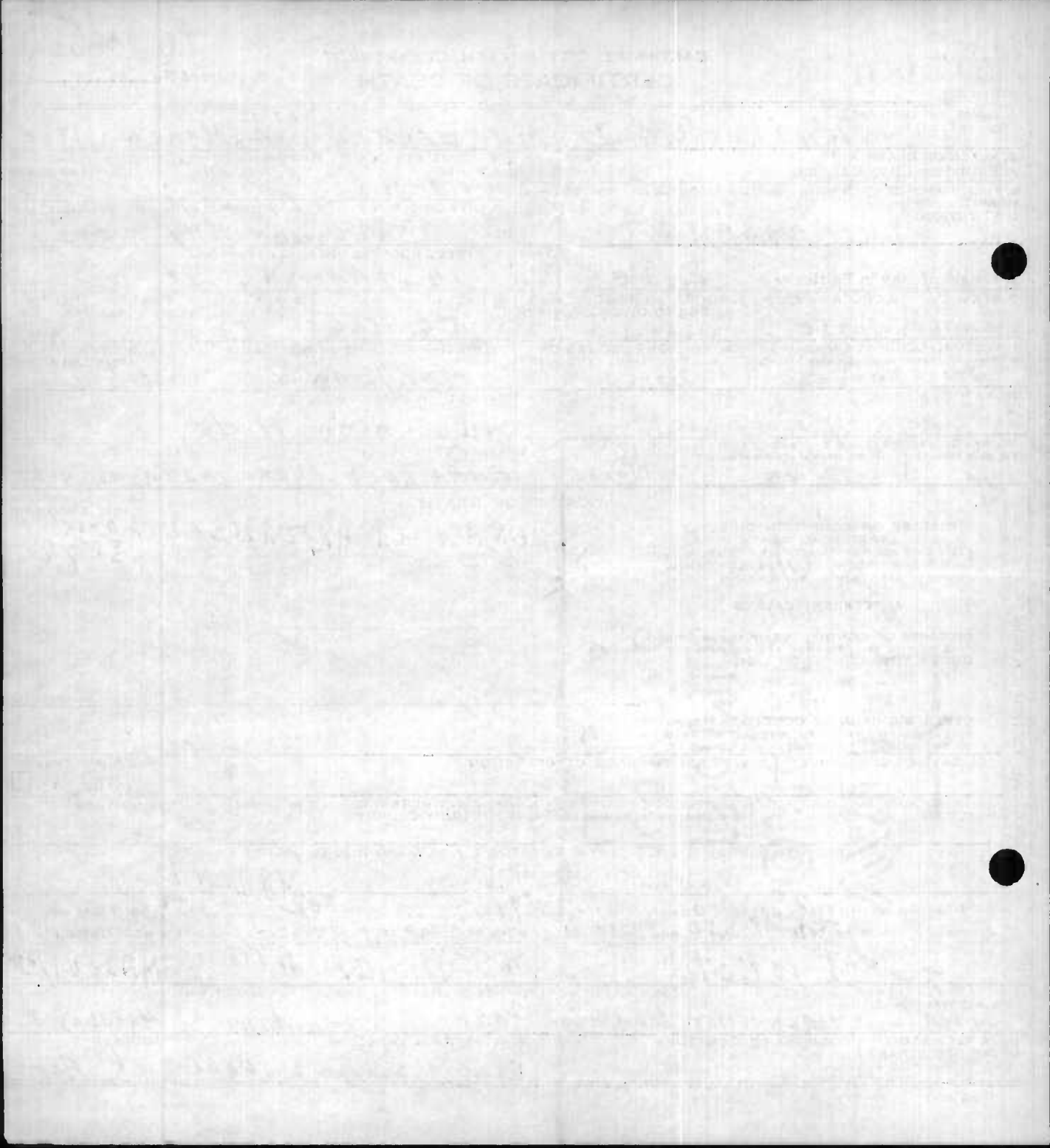
REGISTRAR'S SIGNATURE

Wife for William

25. FUNERAL DIRECTOR

ADDRESS

GEO. L. Schwab 2101 Frederick Ave.



462
50 1852BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1852

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <i>Mrs. Wanietta M. Clark</i>		2. DATE OF DEATH <i>March 2, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md.</i> COUNTY <i>Baltimore</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <i>Maryland General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 20-03</i>	
Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>222 S. Payson St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Sept. 13, 1925</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) <i>24</i>
11. BIRTHPLACE (State or foreign country) <i>USA. (Md)</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Weker</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Mews</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Husband</i>		ADDRESS <i>222 S. Payson St.</i>	

18. *057.0* *649X* CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Meningitis (Meningococcus)
DUE TO

INTERVAL BETWEEN ONSET AND DEATH
24 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pregnancy - 6 weeks duration

19A. DATE OF OPERATION
None

19B. MAJOR FINDINGS OF OPERATION
None

20. AUTOPSY?
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2/14*, 19*50*, to *3/2/50*, 19*50*, that I last saw the deceased alive on *3/1*, 19*50*, and that death occurred at *6 A. m.*, from the causes and on the date stated above.

23A. SIGNATURE
Irwin P. Klemkowski

23B. ADDRESS
11 E. Chase St

23C. DATE SIGNED
3/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

24B. DATE
3-6-50

24C. NAME OF CEMETERY OR CREMATORY
LONDON PARK

24D. LOCATION (City, town, or county) (State)
BALTIMORE MD

DATE RECEIVED BY LOCAL REGISTRAR
MAR 3 - 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR
Geo. L. Schwab

ADDRESS
2101 Frederick Ave.

95256

Information obtained from Division of Maternity Hygiene. 6/6/50.

255
50 1853BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1853

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS HICKMAN

2. DATE
OF
DEATH

3/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Annapolis Hospital

C. Length of stay in Baltimore

80 YRS.

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

WIDOWED

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

PLASTERER

10B. KIND OF BUSINESS OR INDUSTRY

Construction

13. FATHER'S NAME

GEORGE HICKMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

NONE

16. SOCIAL SECURITY NO.

216-12-7255

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write M. R. A. I. and give township)

BALTIMORE

20-08

D. STREET ADDRESS (If rural, give location)

337 VALE AVE.

8. DATE OF BIRTH

Aug. 7, 1867

9. AGE (In years last birthday)

82

11 Under 1 Year
Months; Days11 Under 24 Hours
Hours; Min.

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

SARAH MORGAN

17. INFORMANT

ADDRESS

MRS. D. ARRINGTON 337 VALE AVE.

18. 470.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral thrombosis; Arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Atherosclerotic Heart Disease

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Anemia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1, 1950, to 3/2, 1950, that I last saw the deceased alive on 3/2, 1950, and that death occurred at 10:20 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Leen Shassel, M. D.

23B. ADDRESS

Annapolis Hospital

23C. DATE SIGNED

3/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

3-6-50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county) (State)

BALTIMORE, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Geo. L. Schwab 2101 Frederick Ave.

MAR 3 - 1950

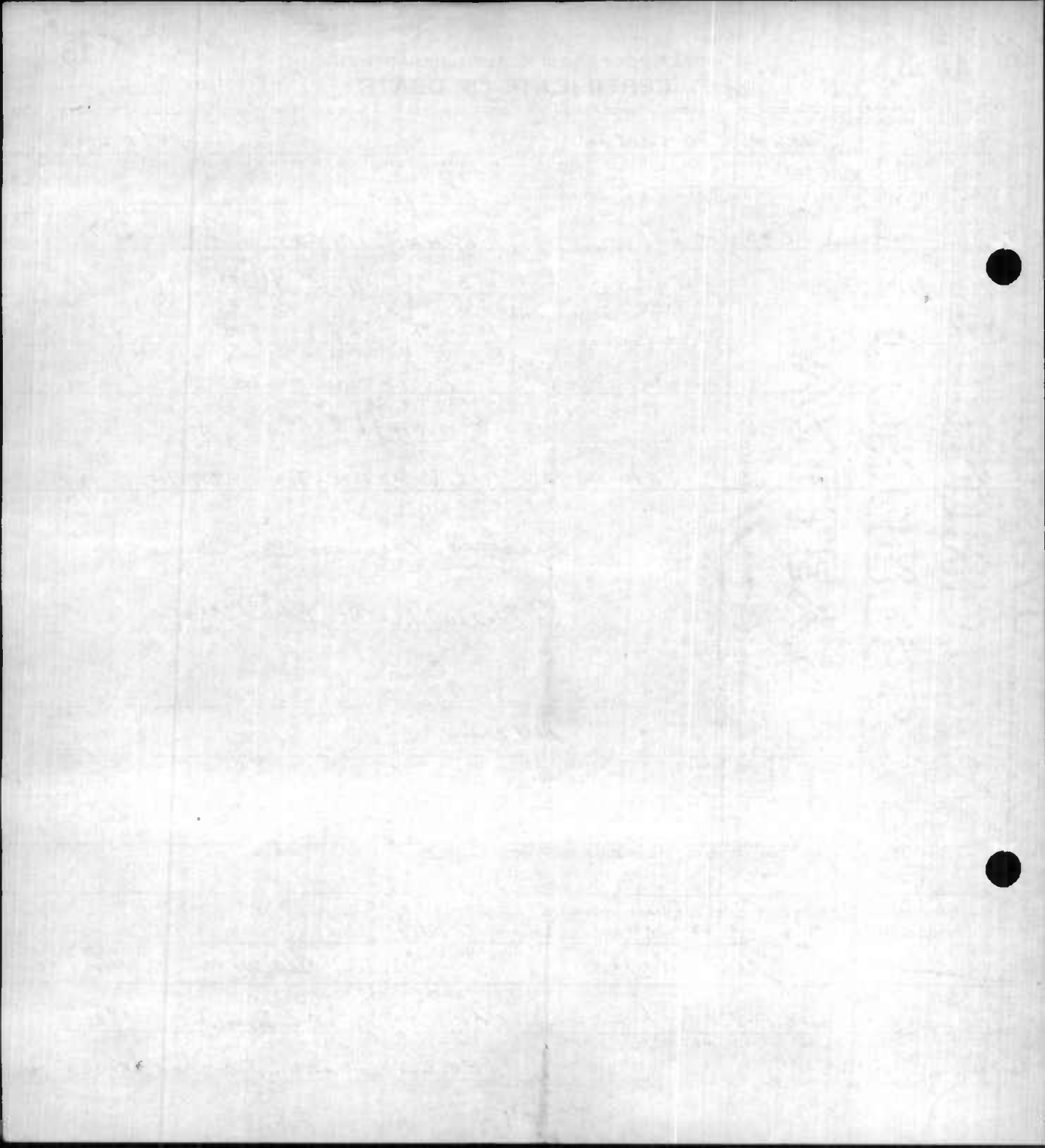
VS 150

346 V9

93D

MEDICAL CERTIFICATION

correct age is especially important. Physicians, please write the cause of death in full.



426
50 1854

50 1854

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. 49-25086

1. NAME OF DECEASED (Type or Print) JOAN WALKER		2. DATE OF DEATH 2/24/50	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE MARYLAND b. COUNTY _____	
b. FULL NAME OF (If not in hospital or institution, give street address or location) UNIV. HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 4-02	
Length of stay in Baltimore 4 mos.		d. STREET ADDRESS (If rural, give location) 658 W. FAIRMOUNT	
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S	8. DATE OF BIRTH 10/22/50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Thomas Walker		14. MOTHER'S MAIDEN NAME Melba Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS Melba Walker	

18. 5740 330X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DIARRHEA & DEHYDRATION ACIDOSIS INTERCRANIAL HEMORRHAGE subarachnoid hemorrhage (over)	CAUSE OF DEATH (A) DIARRHEA & DEHYDRATION DUE TO ACIDOSIS (B) INTERCRANIAL HEMORRHAGE DUE TO subarachnoid hemorrhage (over) (C) _____	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 2/17/50 , 19 50 , to 2/24 , 19 50 ; that I last saw the deceased alive on 2/24 , 19 50 , and that death occurred at 1 m., from the causes and on the date stated above.		

23a. SIGNATURE Lemay Bachner M. D.	23b. ADDRESS UNIV. HOSP BALTO	23c. DATE SIGNED 2/26/50
---	---	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY JOHN HOPKINS MEDICAL SCHOOL	24d. LOCATION (City, town, or county) (State) MAR 1 1950
DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950	REGISTRAR'S SIGNATURE W. Williams	25. FUNERAL DIRECTOR	ADDRESS

Dr Fales discussed case
with Dr Fisher by phone 4-21.50.

Felling was dearked, etc followed
subarachnoid hemorrhage.

Also see letter

Es

50-1854 Document File from University H

520

50 1855

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1855

BIRTH NO. 50-04374

1. NAME OF DECEASED (Type or Print) BABY BOY VINES		2. DATE OF DEATH 22 FEB. '50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 1503 Mosher St. B. COUNTY Balt. City	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital Baltimore, Md		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-02	
D. STREET ADDRESS (If rural, give location) 1503 Mosher St MOSHER,			
5. SEX Male		6. COLOR OR RACE Colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH 25 Feb. 1950	
9. AGE (In years, last birthday) 1/2		10. AGE (In years, last birthday) 1/2	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charlie Vines		14. MOTHER'S MAIDEN NAME Helen Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT		ADDRESS ✓	

18. 762.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia	INTERVAL BETWEEN ONSET AND DEATH 12 hrs
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Atelctasis	1 hr
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible Congenital Syphilis	1 hr

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 2/25 , 19 50 , to 2/27 , 19 50 , that I last saw the deceased alive on 2/27 , 19 50 , and that death occurred at 3:30 A. M. , from the causes and on the date stated above.		
23A. SIGNATURE Raymond B. Beegreen	23B. ADDRESS University Hospital Bldg	23C. DATE SIGNED 2/27/50

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 00	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950	REGISTRAR'S SIGNATURE John Hopkins Medical School	25. FUNERAL DIRECTOR	ADDRESS

JOHN HOPKINS MEDICAL SCHOOL MAR 1 1950

STATE OF NEW YORK
CERTIFICATE OF DEATH

1. Name of Deceased: [illegible]
2. Date of Birth: [illegible]
3. Date of Death: [illegible]
4. Place of Birth: [illegible]
5. Place of Death: [illegible]
6. Cause of Death: [illegible]
7. Signature of Physician: [illegible]
8. Signature of Registrar: [illegible]
9. Date of Registration: [illegible]

-636
50 1856

50 1856

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

CARTER, JOHN

2. DATE
OF
DEATH

2/27/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Provident

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balt. Md. - 16-02

D. STREET ADDRESS (If rural, give location)

1127 Parrish

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

6-10-79

9. AGE (In years last birthday)

70

10. Under 1 Year Months: Days

8 17

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)

Labour

10B. KIND OF BUSINESS OR INDUSTRY

unknown

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S MARRIED NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT ADDRESS

Annie B. Burrell, 1113 Parrish St

18. 330 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Subarachnoid Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

II

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/27 1950 to 2/27 1950 that I last saw the deceased alive on 2/27 1950, and that death occurred at 7:28 p.m., from the causes and on the date stated above.

23A. SIGNATURE

John N. Holmes

M. D.

23B. ADDRESS

Provident Hosp.

23C. DATE SIGNED

2/28/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-4-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION (City, town, or county) (State)

A. A. Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

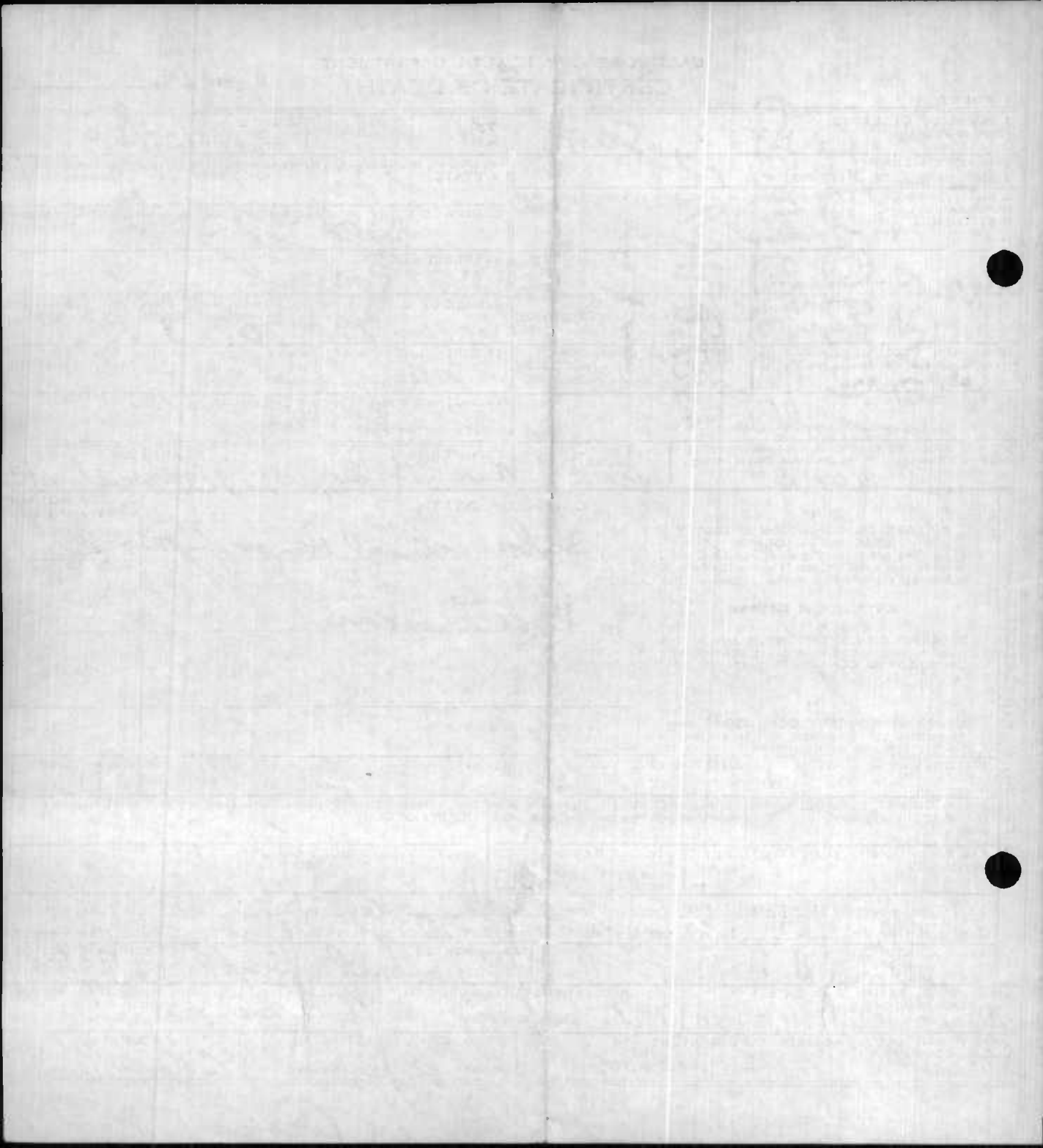
MAR 3 - 1950

William A. Jackson

25. FUNERAL DIRECTOR

ADDRESS

Wm. A. Jackson - 916 Penn. Ave



420

50 1857

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1857
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Wallace

2. DATE
OF
DEATH

3-1-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

1046 Pennsylvania Ave.

Yrs.
Mos.
Days

Length of stay in Baltimore

45 years

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

11-16-97

9. AGE (in years last birthday)

52

If Under 1 Year Months: Days

4 16

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

10B. KIND OF BUSINESS OR INDUSTRY

unknown

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

unknown

14. MOTHER'S M maiden NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NONE

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Agnes Jones - 830 So. Sharp St.

ADDRESS

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular Disease 6 mos

QUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

QUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER- Lying ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-13, 1949 to 3-1, 1950 that I last saw the deceased alive on 3-1, 1950 and that death occurred at 3:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

W. Atwell Jones

23B. ADDRESS

554 Dolphin St

23C. DATE SIGNED

3-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-4-50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

Baltimore 30.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 3 - 1950

REGISTRAR'S SIGNATURE

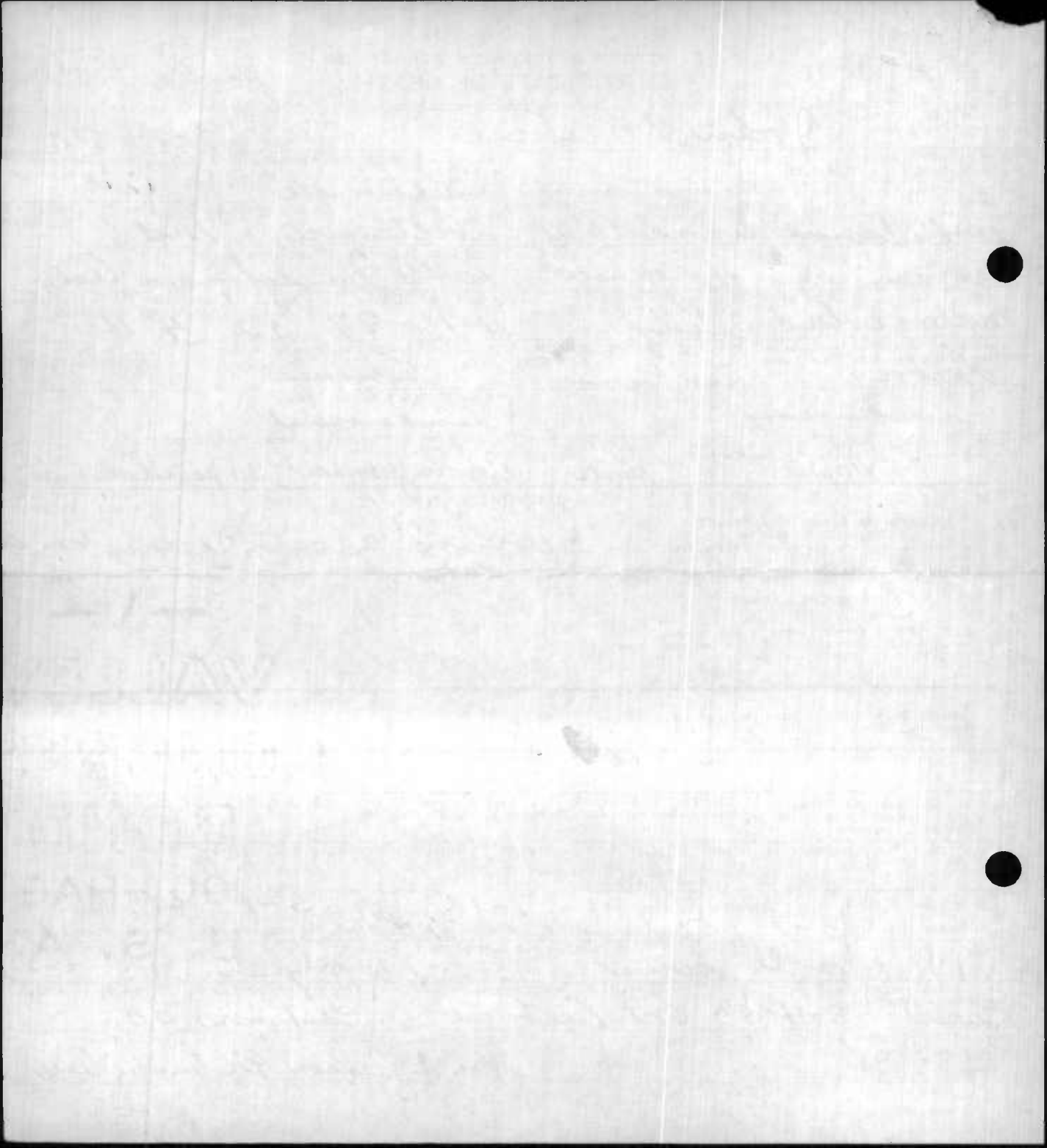
Wm. A. Jackson

25. FUNERAL DIRECTOR

Wm. A. Jackson, 916 Penna. Ave.,

ADDRESS

contact ag. to determine importance of information. please write the cause of death clearly and legibly.



400
50 1858BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1858
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Naomi Beall</i>			2. DATE OF DEATH <i>Mar 2/1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2647 Dulaney St</i>			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Maryland</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore 20-05</i>		
Length of stay in Baltimore <i>Life</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>2647 Dulaney St</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Nov 27/1881</i>	9. AGE (In years last birthday) <i>68</i>	10. Under 1 Year Months; Days 11 Under 24 Hours Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <input checked="" type="checkbox"/>
13. FATHER'S NAME <i>Edward Boyce</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Martha R Tracy 2647 Dulaney St</i>		

18. <i>443. X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>Branchial Pneumonia 5 Days</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) <i>Apoplexy with Left Hemiplegia 5 months</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C) <i>Hypertensive Heart Disease 10 yrs</i>	CAUSE OF DEATH <i>Branchial Pneumonia 5 Days</i> <i>Apoplexy with Left Hemiplegia 5 months</i> <i>Hypertensive Heart Disease 10 yrs</i>	INTERVAL BETWEEN ONSET AND DEATH
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MEDICAL CERTIFICATION

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>3/2/50 7 P.m.</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Aug. 24, 1949</i> to <i>March 2, 1950</i> that I last saw the deceased alive on <i>March 2, 1950</i> and that death occurred at <i>1:00 P.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Edfred Cole</i> M. D.		23B. ADDRESS <i>1934 Welkins Ave</i>		23C. DATE SIGNED <i>Mar. 2, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>March 6/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>					
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 3 - 1950</i>		REGISTRAR'S SIGNATURE <i>Nancy H. Hinnacast</i>		25. FUNERAL DIRECTOR ADDRESS <i>4204 Ridgemoor Ave</i>	

STATE OF TEXAS

COUNTY OF DALLAS

IN SENATE, FEBRUARY 1, 1907.

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE.

FOR THE YEAR 1906.

BY THE COMMISSIONER,

JOHN W. HAYES.

DAVID W. HAYES,

PRINTED BY THE

STATE OF TEXAS.

1907.

DAVID W. HAYES,

PRINTED BY THE

STATE OF TEXAS.

1907.

DAVID W. HAYES,

PRINTED BY THE

STATE OF TEXAS.

1907.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1859

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) IDA WINIFRED JONES			2. DATE OF DEATH Mar. 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 3027 Windsor Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 15-07B		
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) 3027 Windsor Ave.		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH April 12, 1875		9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME David Fisher			14. MOTHER'S MAIDEN NAME Mary Ellen Alberson		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Mrs. Nina J. Rose 2908 Poplar Terrace		

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u><i>Pulmonary edema</i></u> DUE TO (B) <u><i>Cirrhosis of liver</i></u> DUE TO (C) <u><i>Extensive Cor. Artery Vascular disease</i></u> <u><i>Pericardial arteriosclerosis</i></u>	INTERVAL BETWEEN ONSET AND DEATH <u><i>6 hrs</i></u> <u><i>6 hrs</i></u> <u><i>10 yrs</i></u> <u><i>5 yrs</i></u>
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19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Mar 1*, 19*46*, to *Mar. 1*, 19*50*, that I last saw the deceased alive on *Mar 1*, 19*50*, and that death occurred at *6:35* m., from the causes and on the date stated above.

23A. SIGNATURE *Dorothy H. Robinson* M. D. 23B. ADDRESS *2835 J. Edgar Pkwy* 23C. DATE SIGNED *3/2/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/3/50	24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	24D. LOCATION (City, town, or county) (State) Woodlawn, Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR ADDRESS WM. J. TICKNER & SONS Balto., Md.	

MAR 2 - 1950
VS 150

124B

MEDICAL CERTIFICATION

STATE OF NEW YORK
IN SENATE
JANUARY 13, 1909.

10

REPORT

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531
50 1860BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1860
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES LINDBERRY		2. DATE OF DEATH February 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admision) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 631 Cumberland Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 631 Cumberland Street		5. LENGTH OF stay in Baltimore 37 yrs Yrs. Mos. Days	
6. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug. 18, 1912
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10B. KIND OF BUSINESS OR INDUSTRY Industrial plant	9. AGE (In years last birthday) 37 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James H. Linberry Sr.		14. MOTHER'S MAIDEN NAME Genesta Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Genesta R. Linberry		ADDRESS 631 Cumberland St.	

18. **443X** I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Acute congestive heart failure
DUE TO **Hypertensive cardiovascular disease**

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Carl L. Roy</i>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED Feb. 28, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/3/1950		24C. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore. Md.		24E. FUNERAL DIRECTOR Holland Funeral Home		ADDRESS 1631 Druid Hill Ave.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 3 1950		REGISTRAR'S SIGNATURE <i>for [illegible]</i>		55. FUNERAL DIRECTOR ADDRESS	

412
50 1861

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1861
Registered No.

1. NAME OF DECEASED (Type or Print) Bertina Bell Phillips			2. DATE OF DEATH Mar. 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 715 W. Lanvale St.			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 17-03		
C. Length of stay in Baltimore 70 yrs.			D. STREET ADDRESS (If rural, give location) 715 W. Lanvale St.		
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 3, 1880		9. AGE (In years last birthday) 70 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (Home)		10B. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jacob Berney			14. MOTHER'S MAIDEN NAME Susie Webster		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Daniel Phillips 2521 D. Hill Ave.		

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Coronary Thrombosis (B) Myocarditis (C) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH Instantly Gradual
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April 1948 to Mar 1, 1950 that I last saw the deceased alive on Mar 1, 1950, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE M. D. M. Rooley	23B. ADDRESS 1403 Park Ave Baltimore Md	23C. DATE SIGNED 3/2/50
-----------------------------------	--	----------------------------

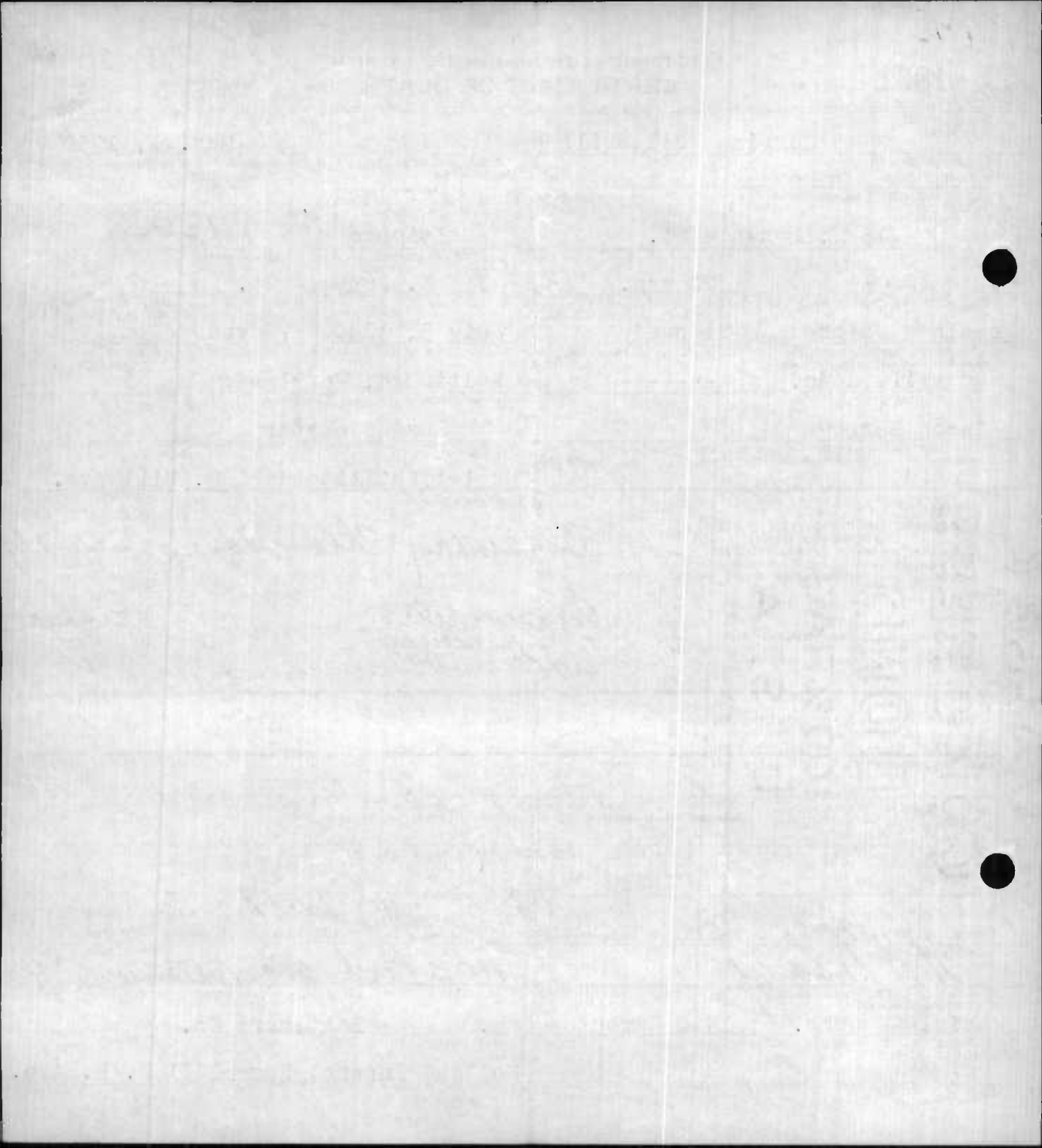
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE Mar. 6, 1950	24C. NAME OF CEMETERY OR CREMATORY Arbutus Cem.	24D. LOCATION (City, town, or county) (State) Baltimore Co.
---	---------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR Holland Funeral Home 1631 D. H. Ave.	ADDRESS
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MEDICAL CERTIFICATION

150 00001863

93D



520
50 1862BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1862

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

OZELLA BLANDER DUNGEE

2. DATE
OF
DEATH

March 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION 2018 McKean Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2018 McKean Ave.

C. Length of stay in Baltimore

24 yrs.

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

Female

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 5, 1905

9. AGE (In years
last birthday)

44 45

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Calvert Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Willis Y. Sewell

14. MOTHER'S MAIDEN NAME

Mary Francis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Thomas E. Dungee 2018 McKean Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Hemorrhagic Pleural Effusion

2 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Varus Pneumonia

3 Months

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 19, 1950, to March 2, 1950, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

844 N. Carey St. Balt. Md.

23C. DATE SIGNED

3/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/5/1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Pk.

24D. LOCATION (City, town, or county)

Baltimore Co. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

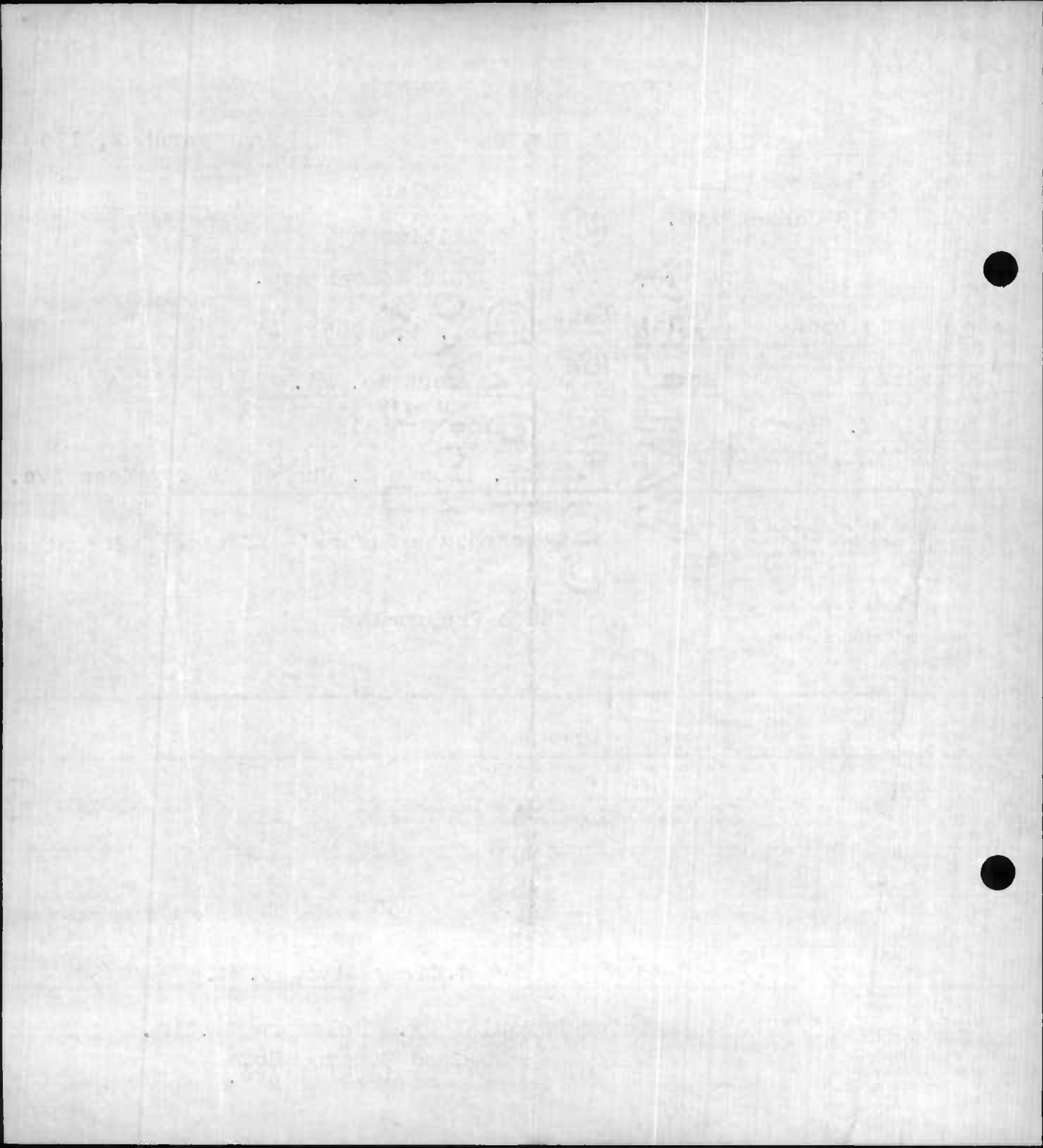
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 3 - 1950

Holland Funeral Home
1631 Druid Hill Ave.



625
50 1863
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1863
Registered No.

1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
E. WILSON HARKINS			Mar. 1, 1950		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			a. STATE Md.		
3014 W. Lanvale St.			b. COUNTY		
c. Length of stay in Baltimore			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) 3014 W. Lanvale St.		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months Days Hours Min.
male	white	married	Oct. 1, 1876	73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Salesman (rtd)			Md.		
10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
Weather Stripping					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph R. Harkins			Lourenna Robinson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
no			218-22-4771		
17. INFORMANT			ADDRESS		
Miss Sara L. Harkins			3014 W. Lanvale St.		

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <u>Cerebral Thrombosis</u> DUE TO	INTERVAL BETWEEN ONSET AND DEATH 36 hours
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <u>Hypertension Cerebral vascular disease</u> DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) <u>Old Cerebral vascular disease</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1947, 19, to March 1, 1950, that I last saw the deceased alive on 3/1, 1950, and that death occurred at 9 P. M., from the causes and on the date stated above.

23a. SIGNATURE <u>W. H. Townsend</u>	23b. ADDRESS M. D. 14 E. Edge St	23c. DATE SIGNED 3/4/50
---	-------------------------------------	----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/4/50	24c. NAME OF CEMETERY OR CREMATORY Deer Creek Cem.	24d. LOCATION (City, town, or county) (State) Harford Co., Md.
---	---------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950	REGISTRAR'S SIGNATURE <u>Wm. J. Tickner & Sons</u>	25. FUNERAL DIRECTOR WM. J. TICKNER & SONS	ADDRESS Balto., Md.
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VALLEY

HEALTH

DEATH

REPORT

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50 1864

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. _____

50 1864
BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) (EVERA) EVA LEE DREW (EVERA) EVA LEE DREW			2. DATE OF DEATH 3/1/50		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MD b. COUNTY _____		
b. FULL NAME OF HOSPITAL OR INSTITUTION 516 N. GILMOR ST			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE		
c. Length of stay in Baltimore 30 yrs			d. STREET ADDRESS (If rural, give location) 516 N. GILMOR ST		
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH L/21/1883	9. AGE (in years last birthday) 67	10. Under 1 Year Months: 1 Days: 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) VA.		
10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ANDERSON HENRY			14. MOTHER'S MAIDEN NAME MALINDA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NO			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT CLARA DREW (D)			ADDRESS 516 N. GILMOR ST		

18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 mo
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypertension		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/1 19 49 , to 3/1 19 50 , that I last saw the deceased alive on 3/1/50 , and that death occurred at 7:40 pm, from the causes and on the date stated above.					
23a. SIGNATURE H. H. Welton		23b. ADDRESS 119 H. H. Welton Ave		23c. DATE SIGNED 3/2/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/15/50		24c. NAME OF CEMETERY OR CREMATORY Mt Sinai Baptist Cem	
24d. LOCATION (City, town, or county) (State) Isle of White, Smithfield Co.		24e. FUNERAL DIRECTOR CHARLES G. COOPER-512 N. CARROLLTON AV		24f. ADDRESS	

DATE RECEIVED BY LOCAL REGISTRAR: **MAR 3 - 1950**
VS 150

MEDICAL CERTIFICATION

83a

455
50 1865BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1865

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JOHN COLEMAN

2. DATE
OF
DEATH

March 3-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore City*B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)*St. Paul Convalescent Home*
2305 St. Paul St.

4. USUAL RESIDENCE (Where deceased lived. If in institution, residence before admission)

A. STATE *2118 Dexter Ave. Md.*B. COUNTY *Montgomery*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Silver Spring

D. STREET ADDRESS (If rural, give location)

5. Length of stay in Baltimore

3 Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Widowed*

B. DATE OF BIRTH

*Feb. 21-1886*9. AGE (In years,
last birthday)*64*10. Under 1 Year
Months: Days*- 10*11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Locomotion Engineer*10B. KIND OF BUSINESS OR
INDUSTRY*N. Y. C. R.R.*

13. FATHER'S NAME

Patrick Coleman

11. BIRTHPLACE (State or foreign country)

*Ireland*12. CITIZEN OF
WHAT COUNTRY?*U. S.*

14. MOTHER'S MAIDEN NAME

*Unknown*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)*2*16. SOCIAL
SECURITY NO.

17. INFORMANT

James Coleman 2118 Dexter Ave. Silver Spring

ADDRESS

18. *151X*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *Generalized Carcinoma* 3 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Gastric Carcinoma* 1 yr.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C) *Atherosclerotic Heart Disease* ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 25, 1950*, to *Mar 3, 1950*, that I last saw the
deceased alive on *Mar 3, 1950*, and that death occurred at *6:30 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

Robert B. Terrence M. D.

23B. ADDRESS

920 St Paul St

23C. DATE SIGNED

*3-3-50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)*Removal*

24B. DATE

3/3/50

24C. NAME OF CEMETERY OR CREMATORY

Riverside Cemetery

24D. LOCATION (City, town, or county) (State)

*Negasa Falls N. Y.*DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*MAR 3-1950**John J. Connelly**John J. Connelly Essex*

50 1953

50

DEPARTMENT OF DEFENSE

51 50 1866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1866

BIRTH NO.

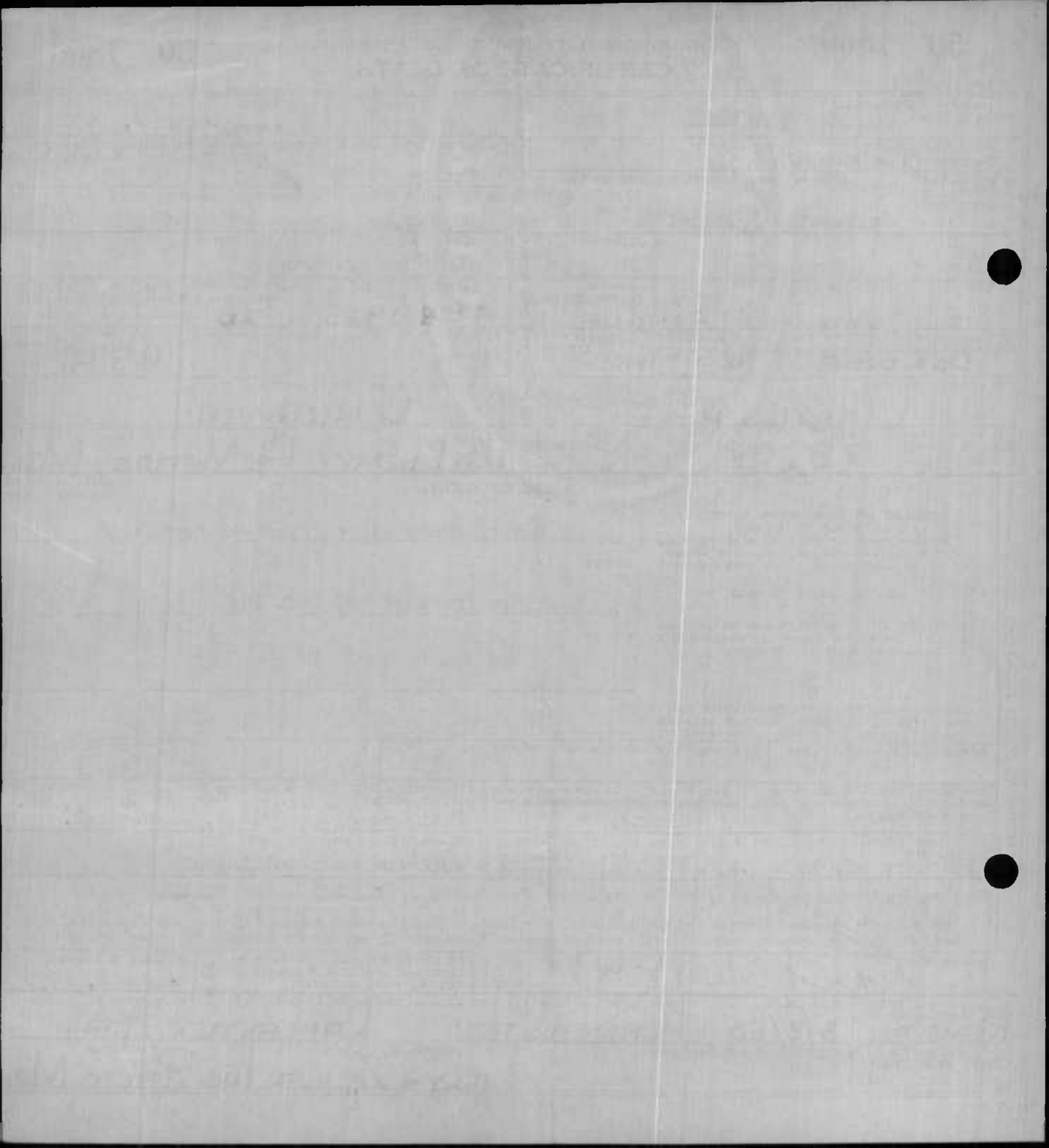
1. NAME OF DECEASED (Type or Print) JOSEPH TRIMBLE		2. DATE OF DEATH March 2, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster	
b. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lancaster	
d. STREET ADDRESS (If rural, give location) 108 Chester Street		e. LENGTH OF STAY IN BALTIMORE Yrs. 0 Mos. 0 Days 0	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 4/24/1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	9. AGE (In years last birthday) 26 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. ?	
17. INFORMANT U.S. ARMY - Ft. Meade, Md.		ADDRESS	

18. E816.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary edema due to cerebral contusion	CAUSE OF DEATH (A) Pulmonary edema due to cerebral contusion DUE TO	INTERVAL BETWEEN ONSET AND DEATH
19. Multiple fractures of left leg DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Multiple fractures of left leg	(B) Multiple fractures of left leg DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Elkridge, Howard County, Md. Patapsco River Bridge, Wash. Blvd.
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY February 28, 1950 2.25a.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? auto and taxi collision

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE Earl L. Boyle	23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23c. DATE SIGNED March 2, 1950
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 3/3/50	24c. NAME OF CEMETERY OR CREMATORY LANCASTER
24d. LOCATION (City, town, or county) (State) LANCASTER, PA.	25. FUNERAL DIRECTOR HILLY & ZEILER INC. BALTO. MD.	ADDRESS



20
50 1867BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1867
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Celestia Dietz

2. DATE
OF
DEATH

3-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

University Hospital

Yrs.
Mos.
Days

Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

3/29/1906

9. AGE (In years
last birthday)11 Under 1 Year
Months Days

4 3

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF
WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Albert Palmer

14. MOTHER'S MAIDEN NAME

Dorothy Palmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

None

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Anthony Dietz - same

18. 171X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Carcinoma, Cervix

13 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

12-1-49 Cordotomy

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-8, 1949 to 2-2, 1950 that I last saw the
deceased alive on 2-2, 1950, and that death occurred at 4:35 p.m., from the causes and on the date stated above.

23A. SIGNATURE

James H. Sheel, Jr. M.D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

3-2-50.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3/8/50

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart Balto. Co. Md.

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

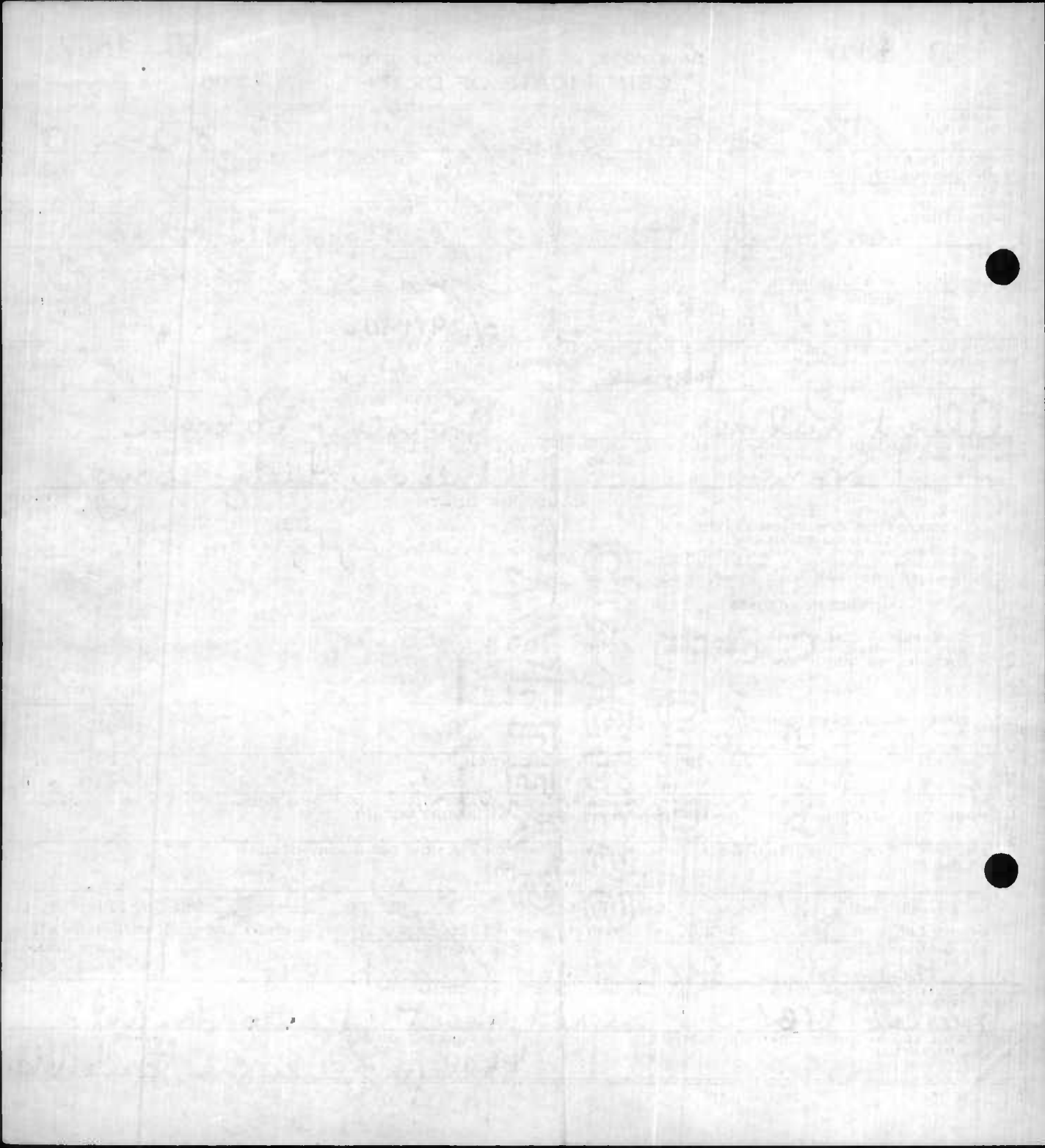
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 3 - 1950

Belly & Zeiler Inc Balto. Md.



534 50 1868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1868
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Anthony Gentile

2. DATE
OF
DEATH

2-28-1950

3. PLACE OF DEATH:
A. Baltimore City, MarylandB. FULL NAME OF
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution; residence
before admission)

A. STATE Md

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore Rural

D. STREET ADDRESS (If rural, give location)

Box 1750 Rd 15

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12-27-99

9. AGE (In years
last birthday)

50

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Sea Captain

10B. KIND OF BUSINESS OR
INDUSTRY

Tug Boat

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Gentile

14. MOTHER'S MAIDEN NAME

Wilhelmina Wilde

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Cardiac failure

DUE TO

4 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Myocardial infarct

DUE TO

4 days

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-25, 1950, to 2-28, 1950, that I last saw the
deceased alive on 2-28, 1950, and that death occurred at 12 M from the causes and on the date stated above.

23A. SIGNATURE

Joseph D. B. King

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

3-2-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Balto. Co. Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

MAR 3 - 1950

25. FUNERAL DIRECTOR

Jelly & Zeller Inc Balto. Md.

ADDRESS

100-10000

Cartwright Family

III

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Agnes Tribull

2. DATE
OF
DEATH

2- 28- 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE MD?

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTIONBaltimore City Hospitals
4940 E₂stern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3135 Dillon ST.

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 19- 1909

9. AGE (In years
last birthday)

40 Yrs.

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

OPERATOR

10B. KIND OF BUSINESS OR
INDUSTRY

Sew MACHINE

13. FATHER'S NAME

Joseph Tribull (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Records B.C.H. 4940 Eastern Ave.

18. 592X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Chronic glomerulonephritis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2- 12- , 1950, to 2- 28 - , 1950, that I last saw the
deceased alive on 2- 28- , 1950, and that death occurred at 6.02AM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

B.C.H. 4940 Eastern Ave.

2-28-1950.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 3-1950

[Signature]

Hilly & Zeller Inc. BALTO. MD.

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

520
50 1870

50 1870

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) Lillian Long 2. DATE OF DEATH Feb. 28, 1950

3. PLACE OF DEATH: A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Mo. B. COUNTY _____

B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 16-04

C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____ D. STREET ADDRESS (If rural, give location) 1827 Mosher St.

5. SEX Female 6. COLOR OR RACE Col. 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH Nov. 27, 1914 9. AGE (In years last birthday) 35 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) Chester SC. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alexander Walker 14. MOTHER'S MAIDEN NAME Mary Hope

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT Lus Long ADDRESS 1827 Mosher St.

18. 572.1 CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Intussusception of cecum caused by multiple polyps & diverticula. Secondary Peritonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) None (C) _____

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Non Functioning gallbladder 2/9/50

19A. DATE OF OPERATION 2/18/50 19B. MAJOR FINDINGS OF OPERATION Same as above 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City give exact location) _____

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

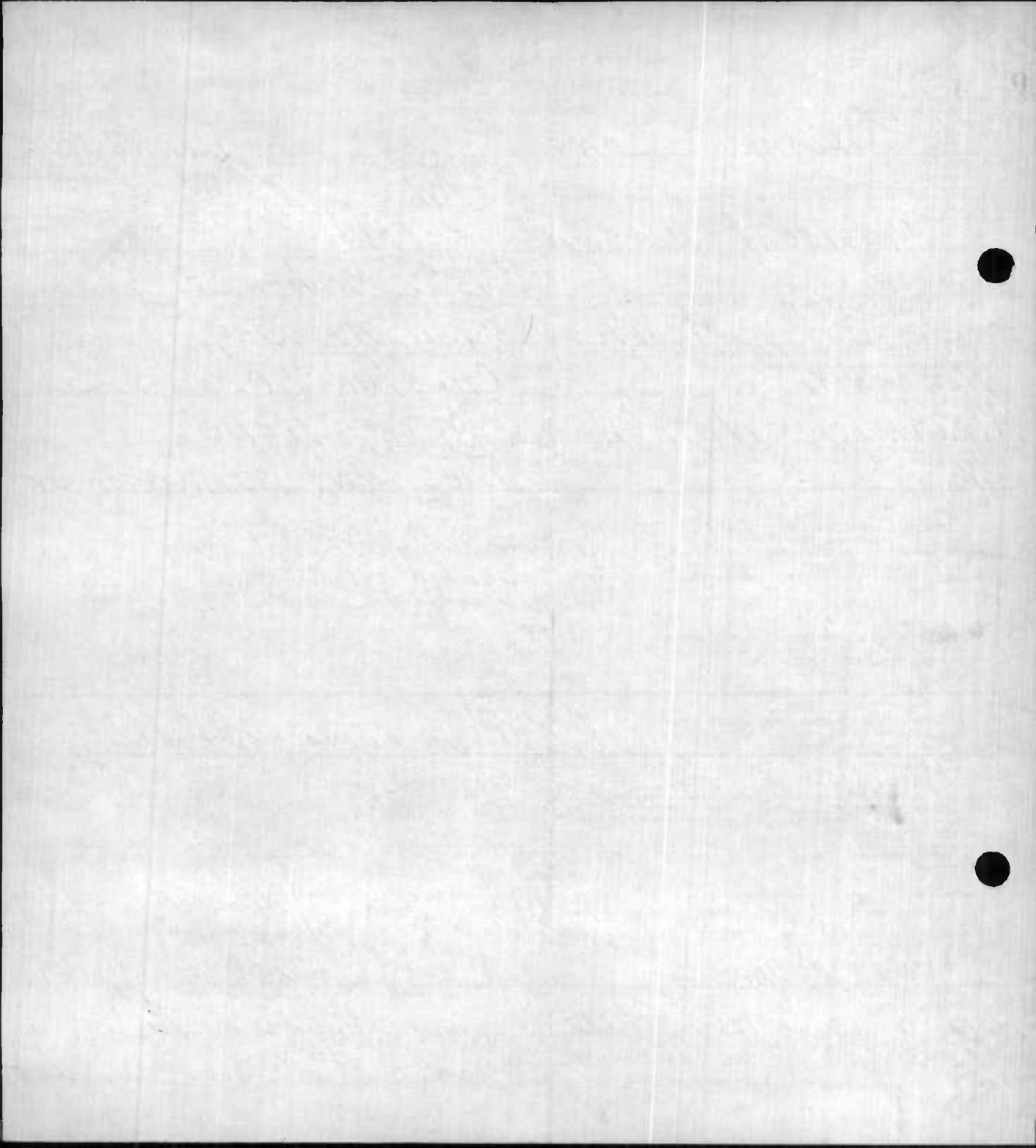
22. I hereby certify that I attended the deceased from 2/9, 1950, to 2/28, 1950, that I last saw the deceased alive on 2/28, 1950, and that death occurred at 2:00 m., from the causes and on the date stated above.

23A. SIGNATURE H. C. Welton M. D. 23B. ADDRESS 1151 Harlem Ave 23C. DATE SIGNED 3/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Shipped 24B. DATE 3-3-1950 24C. NAME OF CEMETERY OR CREMATORY Chester 24D. LOCATION (City, town, or county) (State) Chester S.C.

DATE RECEIVED BY LOCAL REGISTRAR MAR 5 1950 REGISTRAR'S SIGNATURE _____ 25. FUNERAL DIRECTOR Mrs. Kate R. Williams ADDRESS 322 N. Schuylkill

MEDICAL CERTIFICATION

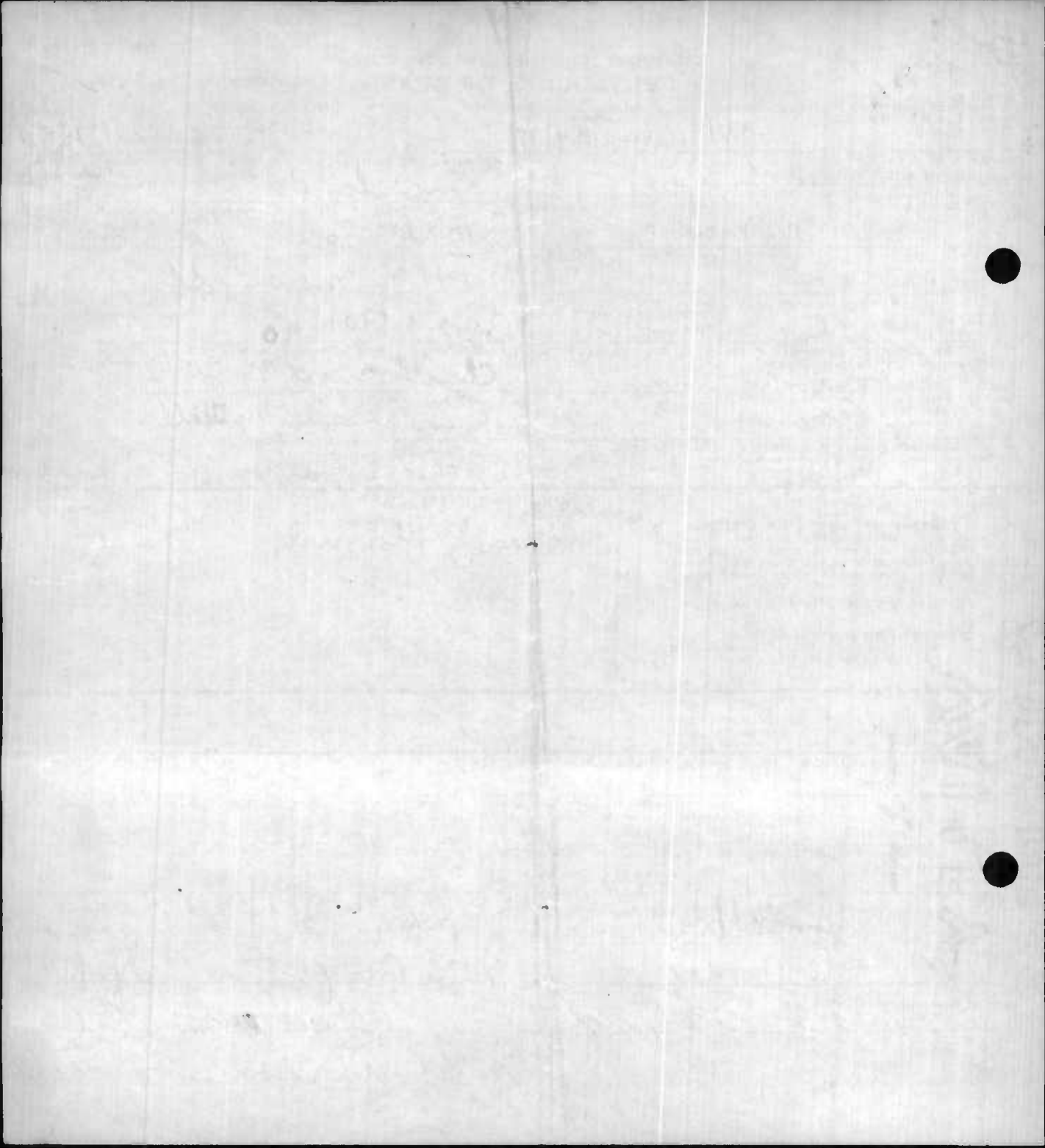


460
50 1871

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1871
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		
William Taylor.		March 1, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION 1141 N. Mount St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-03		
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1141 N. Mount St.		
S. SEX Male	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug. 8, 1909.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour - at P. & S.		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 40	
11. BIRTHPLACE (State or foreign country) Chadbourne, N.C.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Roy Taylor.		14. MOTHER'S MAIDEN NAME Savannah, N. Hill.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II.		16. SOCIAL SECURITY NO.		
17. INFORMANT Catherine Taylor.		ADDRESS 1141 N. Mount St.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 151X I (CAUSE OF DEATH) Cancer of Throat (A) ... DUE TO (B) ... DUE TO (C) ... INTERVAL BETWEEN ONSET AND DEATH ?			19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) ... DUE TO (C) ...	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?		
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		
22. I hereby certify that I attended the deceased from 1/20 to 2/11/50, that I last saw the deceased alive on 4-20-1950 and that death occurred at 4-20-1950 from the causes and on the date stated above.				
23A. SIGNATURE Wm. G. Gurner		23B. ADDRESS 753 Gesset		
23C. DATE SIGNED 3/3/50		23D. SIGNATURE M. D.		
24A. BURIAL, CREMATION, REMOVAL (Specify) Shipped		24B. DATE 3-3-1950		
24C. NAME OF CEMETERY OR CREMATORY Chadbourne		24D. LOCATION (City, town, or county) (State) Chadbourne N. C.		
DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950		REGISTRAR'S SIGNATURE Miss. for William		
25. FUNERAL DIRECTOR Mrs. Kate R. Williams		ADDRESS 322 N. Schuylers St.		



520
50 1872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1872
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Herman Jones

2. DATE
OF
DEATH

Feb. 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

267 1/2 Epter St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

laborer

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Clum Jones.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

8. DATE OF BIRTH

July 27, 1905

9. AGE (In years
last birthday)

44

11 Under 1 Year
Months: Days

11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Greenbay, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Bessie Neal.

17. INFORMANT

Mary Jones. 267 1/2 Epter St.

ADDRESS

CAUSE OF DEATH

18. 422.1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Coronary Arteriosclerosis

5 day.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Cardiovascular disease

1-1 1/2 yrs

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (a.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐

NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Feb 10-50

22. I hereby certify that I attended the deceased from Feb 27, 1950 to 27 Feb, 1950, that I last saw the
deceased alive on 27 Feb, 1950. and that death occurred at 330 P.m., from the causes and on the date stated above.

23A. SIGNATURE

A. C. Burwell

M. D.

23B. ADDRESS

121 Airway St

23C. DATE SIGNED

27 Feb 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

DATE RECEIVED BY
LOCAL REGISTRAR

MAR 3 - 1950

24B. DATE

3-3-1950

24C. NAME OF CEMETERY OR CREMATORY

Farmville Va.

24D. LOCATION (City, town, or county)

Farmville Va

(State)

REGISTRAR'S SIGNATURE

DATE RECEIVED BY
LOCAL REGISTRAR

25. FUNERAL DIRECTOR

Mrs. Kate R. Williams

ADDRESS

322 N. Schuman St



500
50 1873

50 1873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

James Mann

2. DATE
OF
DEATH

February 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR
INSTITUTION

317 N. Schroder St.

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

18-01

D. STREET ADDRESS (If rural, give location)

317 N. Schroder Street

C. Length of stay in Baltimore

25

5. SEX

Male

6. COLOR OR RACE

C

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1899

9. AGE (in years,

last birthday)

51

11 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maneto, N.C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James Mann

14. MOTHER'S MAIDEN NAME

Molly Jarvis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Anna Gallop - 929 W. Lexington St.

18. 148. X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of Throat

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Metastasis

DUE TO

6 mos.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 5, 1949, to Feb. 28, 1950, that I last saw the deceased alive on Feb. 28, 1950, and that death occurred at 6 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

600 N. Arlington Avenue 2-28-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 3 - 1950

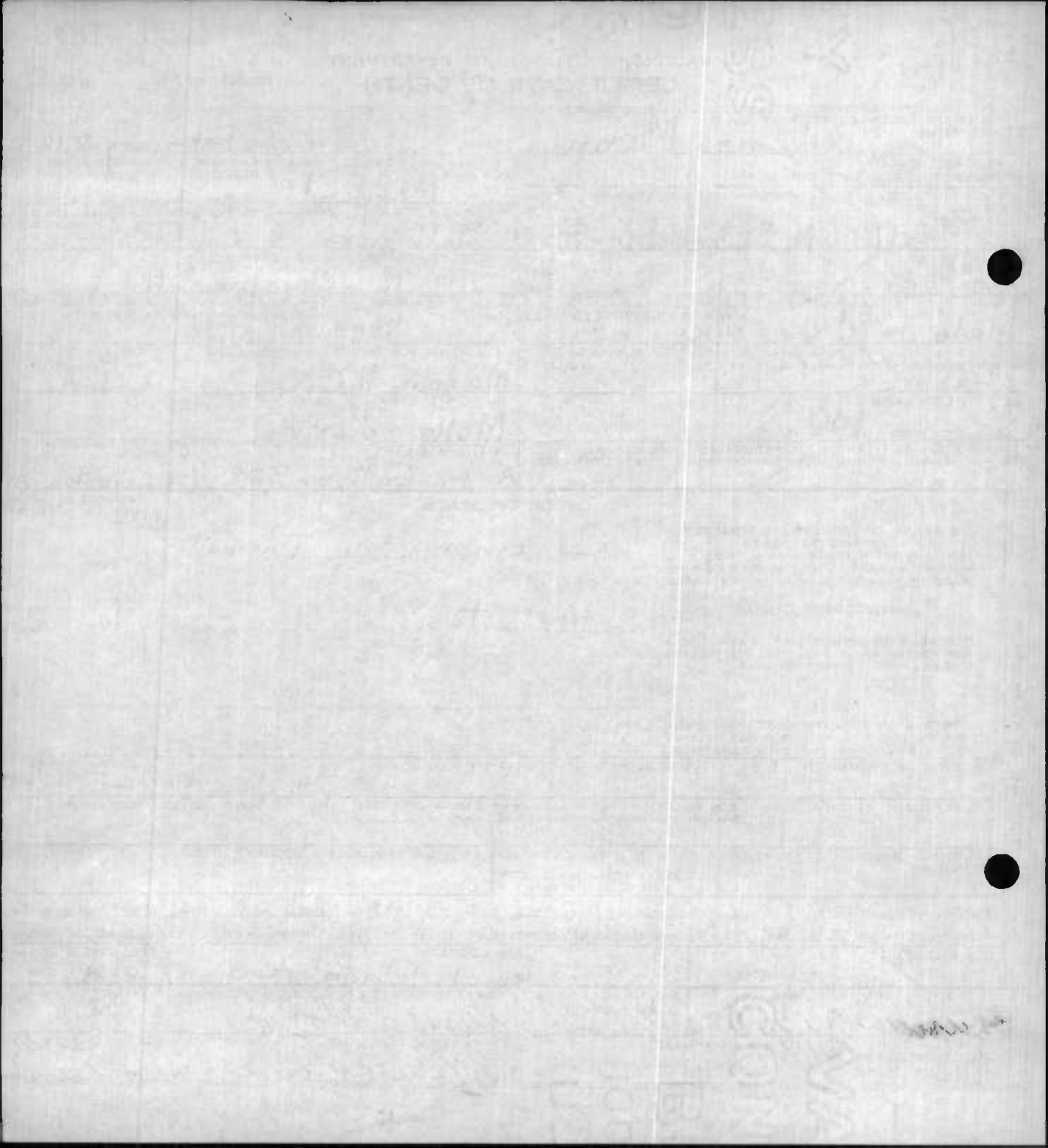
My Kate R. Williams Schindler St

VS 150

98899 1 8 7 5

45F

MEDICAL CERTIFICATION



653
50 1874BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1874
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DR. JOHN CHRISTIAN KRANTZ

2. DATE
OF
DEATH

Mar. 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

Dr. Beck's Clinic

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1052 N. Broadway

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Dec. 7, 1863

9. AGE (in years
last birthday)

83

11 Under 1 Year
Months: Days12 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Pharmacist

10B. KIND OF BUSINESS OR
INDUSTRY

Owner, Drug store Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Krantz

14. MOTHER'S MAIDEN NAME

Margarite Buchheimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT Ellenham Rd. Ruston, Md.
Dr. John C. Krantz, Jr.

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) ...

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) ...

DUE TO

(C) ...

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 14, 1950, to Mar 1, 1950, that I last saw the
deceased alive on Mar 1, 1950, and that death occurred at 7:22 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

3/3/50

24C. NAME OF CEMETERY OR CREMATORY

Druid Ridge Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

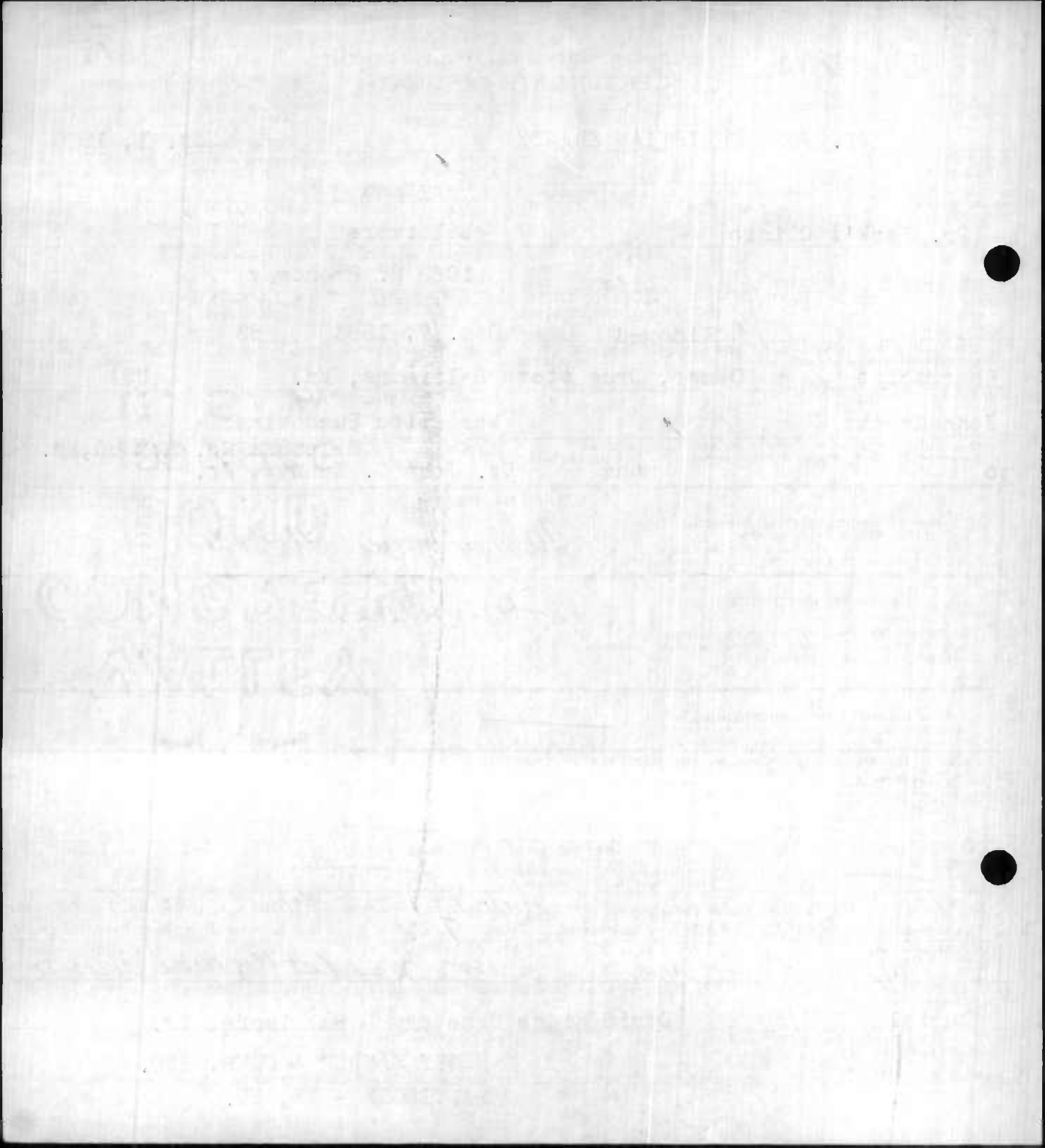
ADDRESS

HENRY SANDER & SONS, INC.

BALTIMORE - 13, MD.

MAR 3 - 1950
VS 150

837



5-530
50 1875BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1875
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SCHMID, WILLIAM FREDERICK

2. DATE
OF
DEATH

MAR 2 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

Length of stay in Baltimore

UNK.

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

MARYLAND

B. COUNTY

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

27-03

D. STREET ADDRESS (If rural, give location)

3311 AILSA AVENUE

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

Nov 23, 1889

9. AGE (In years
last birthday)

60

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

WORKS MANAGER

10B. KIND OF BUSINESS OR
INDUSTRY

RIVER BRASS & COPPER

11. BIRTHPLACE (State or foreign country)

PENNSYLVANIA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

FREDERICK SCHMIDT

14. MOTHER'S MAIDEN NAME

LOUISE KOHN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

UNK

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

HAS W.F. SCHMID - 3311 AILSA AVE

18. 203. X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) MULTIPLE MYELOMA

DUE TO

± 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 1/7, 1950, to 3/2, 1950, that I last saw the
deceased alive on 3/1, 1950 and that death occurred at 3:10 pm, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

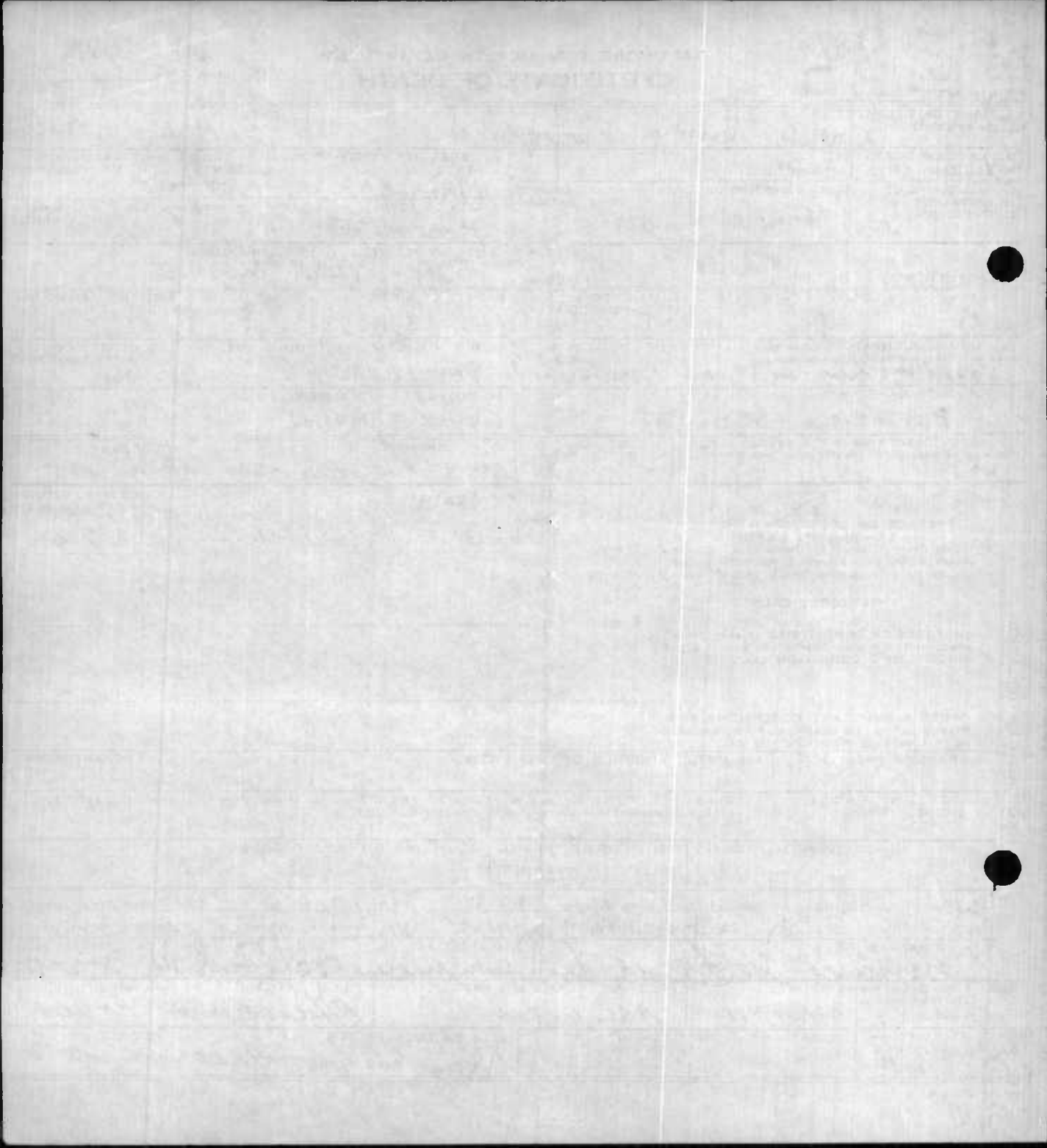
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



H-41

50 1876

BALTIMORE CITY HEALTH DEPARTMENT

50 1876

CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Christian Helfenbein

2. DATE
OF
DEATHMarch 1st 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland 1620 Chillon

b. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE Md

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Bald

9-06

d. STREET ADDRESS (If rural, give location)

1620 Chillon

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Mar 12 1879

9. AGE (In years
last birthday)

70

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10a. USUAL OCCUPATION (Give kind of
work done during most of working life, or, if retired)10b. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Don't Know

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Alvin Helfenbein 1424 Northgate

18. 527.2

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONOITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21e. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an _____ thereon and from _____
Autopsy, Inspection or Inquiry
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

23b. CHIEF MEDICAL EXAMINER.....

23c. DATE SIGNED

M.D. ASSISTANT MEDICAL EXAMINER.....

3-2-50

24a. BURIAL, CREMA-
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

DATE RECEIVED

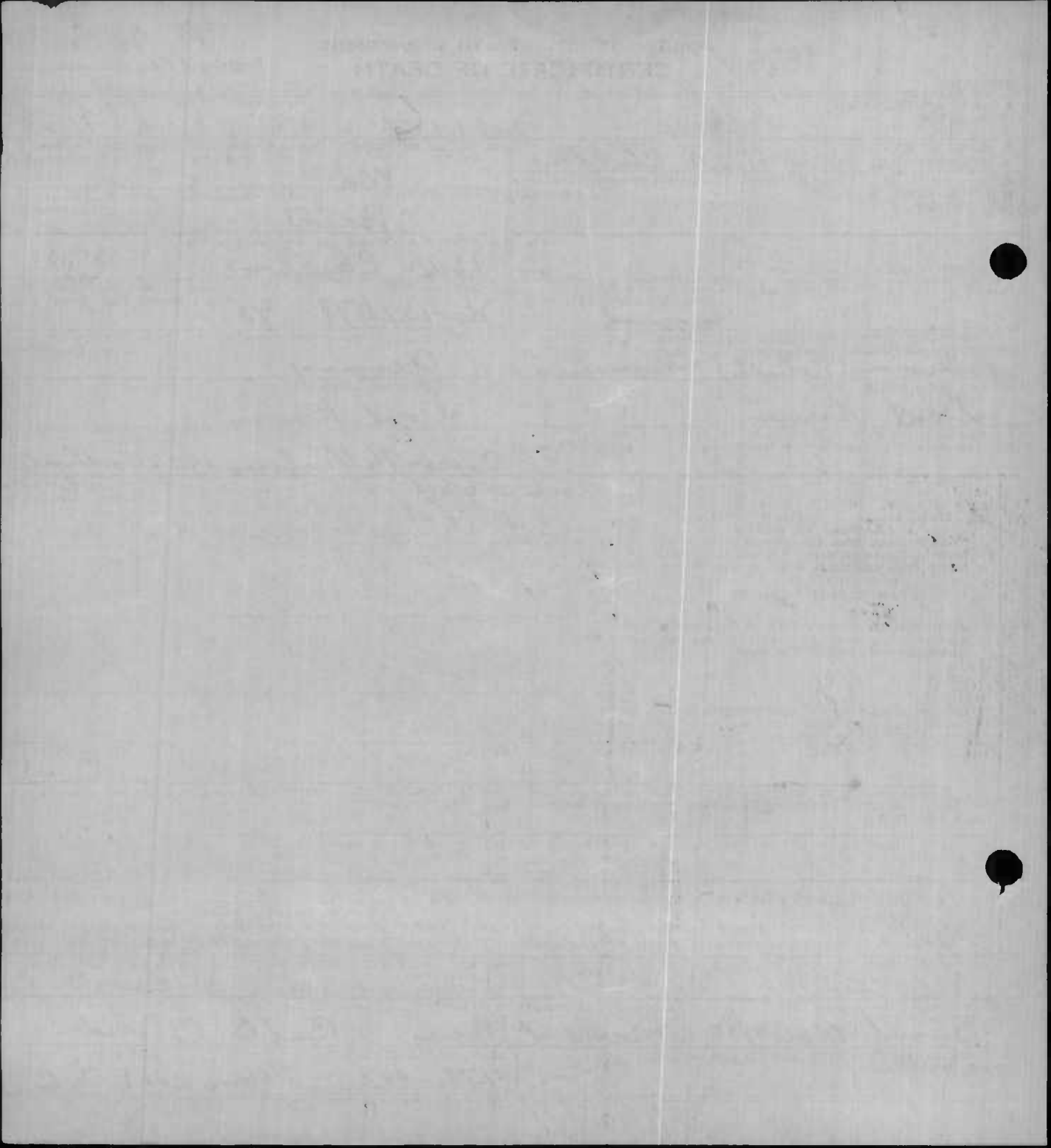
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

LOCAL REGISTRAR

Ullrich Funeral Home 2008 Oliver



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1877

Registered No. _____

BIRTH NO. 50 1877

1. NAME OF DECEASED (Type or Print) <i>John C Martin</i>		2. DATE OF DEATH <i>Mar 2 / 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>921 S Conkling</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Bald</i> <i>26-09</i>	
C. Length of stay in Baltimore <i>60</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>921 S Conkling St</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>May 4 / 1885</i>
9. AGE (In years last birthday) <i>64</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	11. BIRTHPLACE (State or foreign country) <i>Germany</i>
10B. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <i>John Martin</i>		14. MOTHER'S MAIDEN NAME <i>Don't Know</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <i>Mrs Sarah Martin</i>		ADDRESS <i>921 S Conkling</i>	

18. <i>350. X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <i>Barbiturate Poison</i> (A) _____ DUE TO <i>Barbiturate</i> (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
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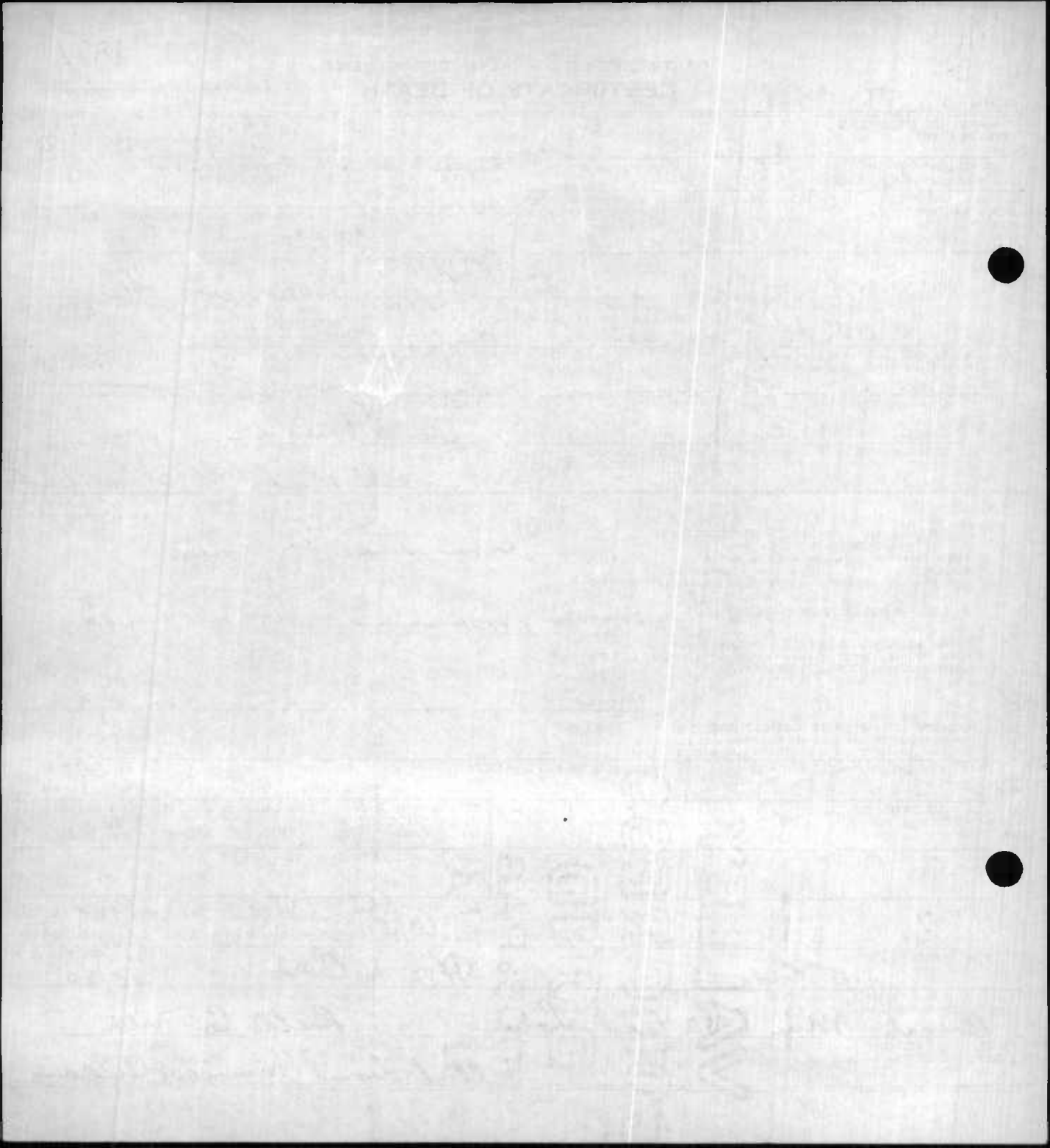
19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <i>2/2</i> ¹⁹⁵⁰ , to <i>3/2</i> ¹⁹⁵⁰ , that I last saw the deceased alive on <i>3/1</i> ¹⁹⁵⁰ , and that death occurred at <i>6:30 A.M.</i> , from the causes and on the date stated above.					

23A. SIGNATURE <i>J. H. [Signature]</i>		23B. ADDRESS <i>3400 2nd St N</i>		23C. DATE SIGNED <i>3/2/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar 6/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>	
		24D. LOCATION (City, town, or county) <i>Bald Co Md</i>		(State) _____	

DATE RECEIVED BY LOCAL REGISTRAR _____		REGISTRAR'S SIGNATURE _____		25. FUNERAL DIRECTOR <i>Ullrich Funeral Home</i>	
				ADDRESS <i>2008 Orleans</i>	

Correct age is especially important. Inquiries: please note the cause of death clearly and legibly.

MEDICAL CERTIFICATION



Dorsett
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1878
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Violet L. Dorsett

2. DATE
OF
DEATH

3/2/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE *md* b. COUNTY *13-08*

b. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

3520 Buena Vista Ave

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore md

d. STREET ADDRESS (If rural, give location)
3520 Buena Vista Ave

Length of stay in Baltimore

Life

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

James H. Dorsett 3520 Buena Vista Ave

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary Disease*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE

23b. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M. D. MEDICAL INVESTIGATOR.....

23c. DATE SIGNED

3/2/50

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 3 - 1950

Wm. J. Williams, Jr.

Burgee Funeral Home 3631 Falls Road

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF NEW YORK

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520
50 1879

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1879

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) <u>Louis J. Jones</u>		2. DATE OF DEATH <u>3-2-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore, Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>23-02</u>	
C. Length of stay in Baltimore <u>Life</u>		D. STREET ADDRESS (If rural, give location) <u>1514 N. Charles St</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11/2 1886</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Jones</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Clay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215 09 4822</u>	
17. INFORMANT <u>Ellen R. Jones</u>		ADDRESS <u>1514 S. Charles St</u>	

18. <u>331X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral hemorrhage</u>		CAUSE OF DEATH (A) <u>Cerebral hemorrhage</u> DUE TO
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Cerebral arteriosclerosis</u>		(B) <u>Cerebral arteriosclerosis</u> DUE TO
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) _____

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/25/50, 1950, to 3/2/50, 1950, that I last saw the deceased alive on 3/2, 1950, and that death occurred at 12 Noon m., from the causes and on the date stated above.

23A. SIGNATURE <u>Dr. D. J. Gagliardi</u>		23B. ADDRESS <u>1213 Light Street</u>		23C. DATE SIGNED <u>2/3/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>March 6, 1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	
24D. LOCATION (City, town, or county) (State) <u>Balt. Co. Md.</u>		25. FUNERAL DIRECTOR <u>C. Howard Jones</u>		ADDRESS <u>1400 S. Charles St</u>	

DATE RECEIVED BY LOCAL REGISTRAR
MAR 3 - 1950

REGISTRAR'S SIGNATURE
William J. Williams

VS 150
3484 Dr. D. J. Gagliardi MD 83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

Handwritten text, possibly a signature or name, appearing in the middle of the page.

Handwritten text, possibly a signature or name, appearing in the bottom right corner.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. 50 1880

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES BURNS

2. DATE
OF
DEATH

March 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2021 Ashton St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 20-03

D. STREET ADDRESS (If rural, give location)

2021 Ashton St.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Hospital

13. FATHER'S NAME

Unknown

8. DATE OF BIRTH

June 6, 1861

9. AGE (in years, last birthday)

88

If Under 1 Year
Months: Days Hours: Min.

11. BIRTHPLACE (State or foreign country)

Ireland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Burns - 2021 Ashton St.

18. 442 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Pulmonary Edema

48 h.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Myocardial Infarction

44

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Cardio-Renal-Vascular Disease
Cachexia - Malnutrition
Cholesterol - High

4 yr.

4 yr.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

22. I hereby certify that I attended the deceased from Feb 25, 1950, to March 2, 1950, that I last saw the deceased alive on Feb 1, 1950, and that death occurred at 3 4 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

1933 W. Baltimore St.

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/4/50

Cathedral

Baltimore

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

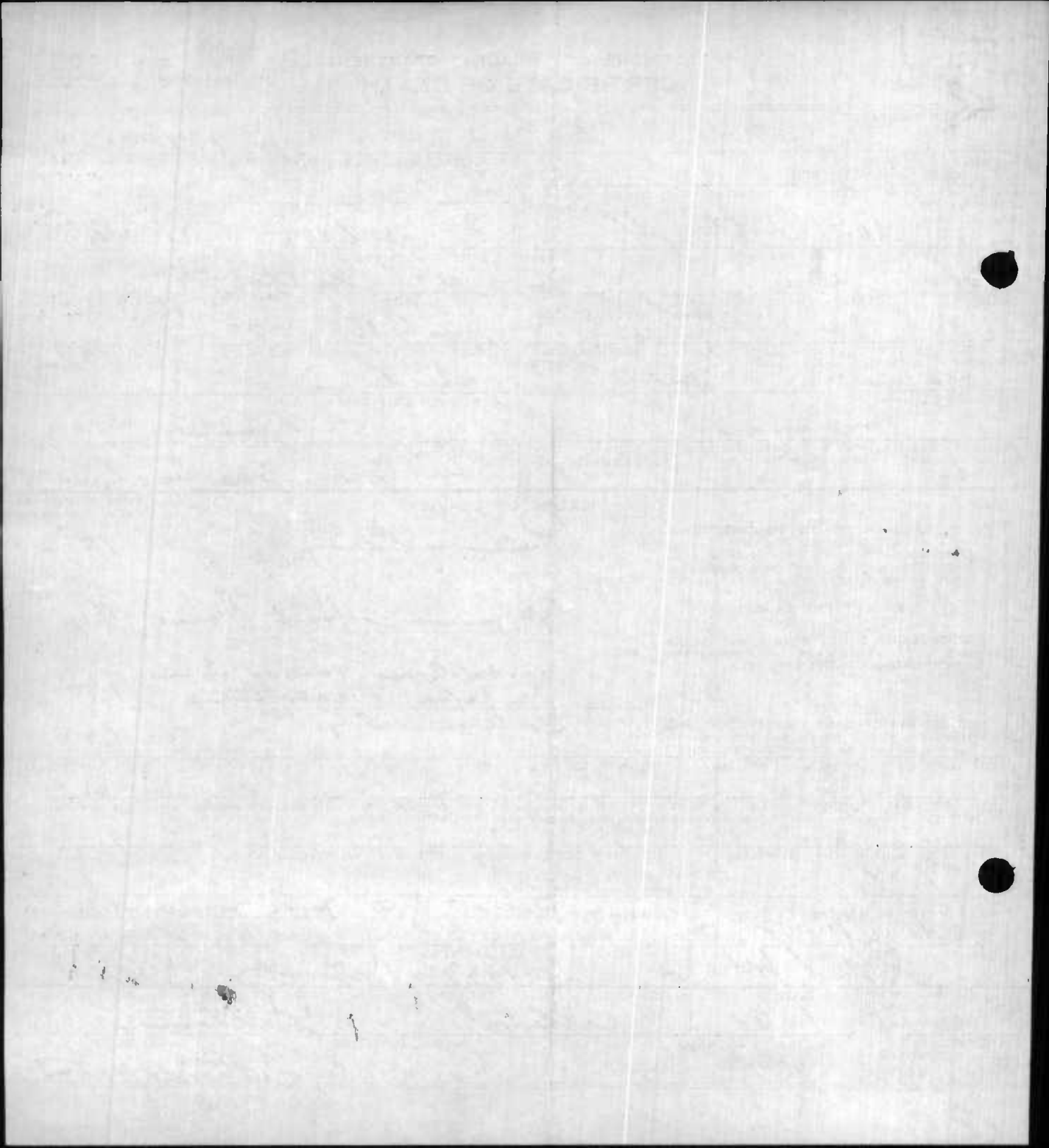
MAR 3 - 1950

Thurston W. Williams

George A. Foley - Fulton Over - Fayette St.

VS 150

131a



-162
1881

SPRECHER

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1881

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)*Newton D. Sprecher*2. DATE
OF
DEATH*March 2, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *3104 Spaulding Ave*B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)4. USUAL RESIDENCE (Where deceased lived. If institution, residence
before admission)

A. STATE

B. COUNTY

*MD Baltimore*C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

D. STREET ADDRESS (If rural, give location)

3104 Spaulding Ave

5. SEX

Male

6. COLOR OR RACE

*White*7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)*Married*

8. DATE OF BIRTH

*July 9, 1870*9. AGE (In years,
last birthday)*79*10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)*Retired Post Office Clerk*10B. KIND OF BUSINESS OR
INDUSTRY*U.S. Post O.*

11. BIRTHPLACE (State or foreign country)

*Hagerstown, Md*12. CITIZEN OF
WHAT COUNTRY?*U.S.A.*

13. FATHER'S NAME

Loggott Sprecher

14. MOTHER'S MAIDEN NAME

*Laura Rush*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs. Newton Sprecher 3104 Spaulding Ave*18. *290 0*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

*Coronary Thrombosis**2 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

*Permanent Anemia**16 yrs.*

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb. 28, 1950* to *March 2, 1950* that I last saw the
deceased alive on *March 2, 1950* and that death occurred at *11:30 a.m.* from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. B. Newman and Hood

M. D.

*2300 Garrison Blvd**3.3.50*24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial**March 4, 1950**St. Paul Lutheran**Hagerstown, Md*DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*MAR 3 - 1950**James J. [illegible]**Spring Byers 5005 [illegible]*

100ND

100%FAC

100%FAC

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1882

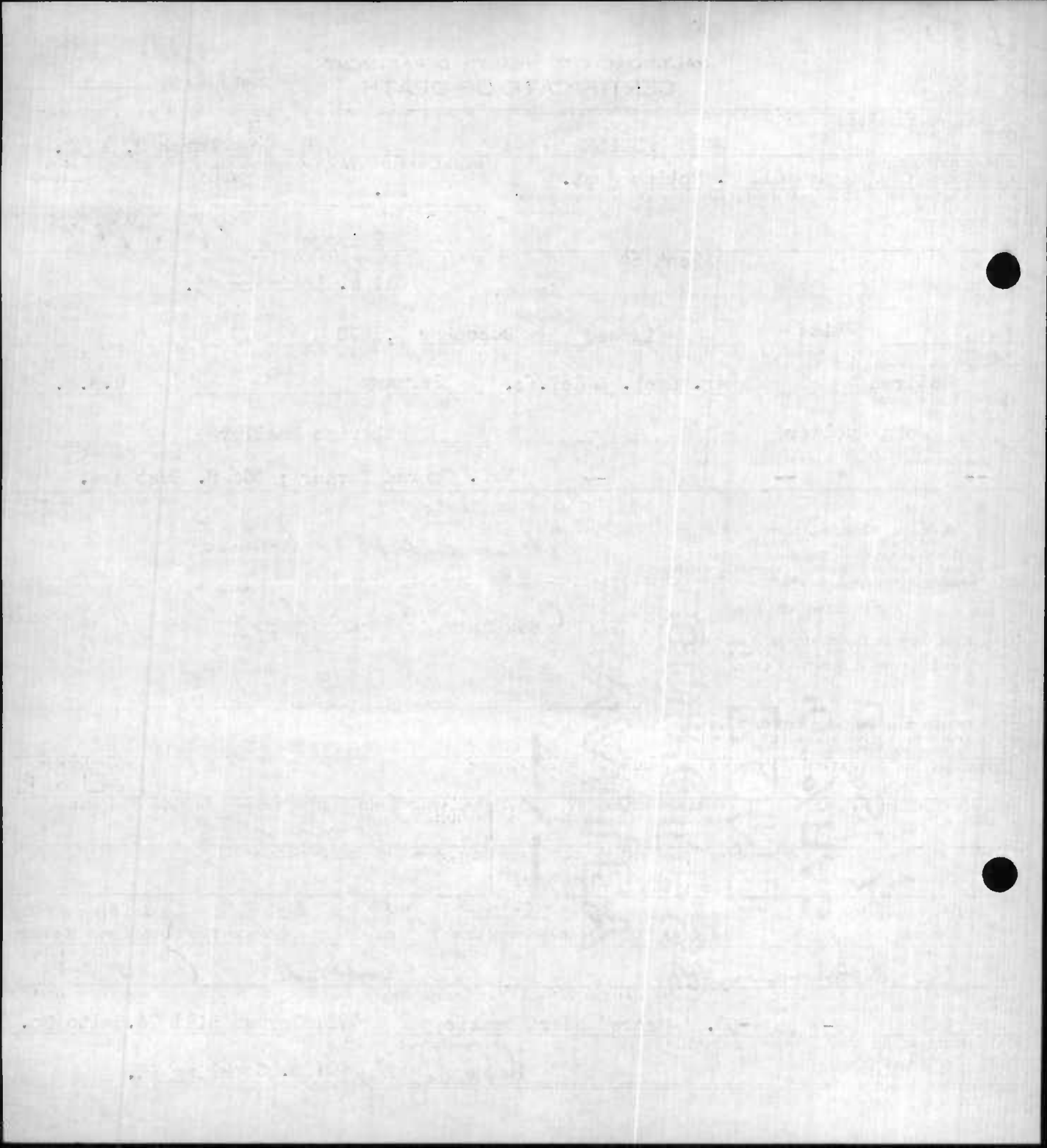
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) JOHN MUELLER		2. DATE OF DEATH March 2, 1950.	
3. PLACE OF DEATH: a. Baltimore City, Maryland 811 S. Robinson St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____	
b. FULL NAME OF HOSPITAL OR INSTITUTION _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
d. Length of stay in Baltimore About 64 Yrs. Mos. Days		e. STREET ADDRESS (If rural, give location) 811 S. Robinson St.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH December 8, 1870
9. AGE (in years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) Germany
10b. KIND OF BUSINESS OR INDUSTRY Amer. Smel. & Ref. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Mueller		14. MOTHER'S MAIDEN NAME Katherine Mueller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Mrs. Conrad Turner ; 606 S. East Ave.		ADDRESS _____	

MEDICAL CERTIFICATION

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic C.V. Disease DUE TO Cerebral Hemorrhage DUE TO 2-23-50			INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION none	19B. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) none	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) none	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY none	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? none	
22. I hereby certify that I attended the deceased from 2-23-1950 , to 3-2-1950 , that I last saw the deceased alive on 3-2-1950 , and that death occurred at 2:30 P. M. , from the causes and on the date stated above.			
23A. SIGNATURE [Signature] M. D.		23B. ADDRESS 842 S. Endwell	23C. DATE SIGNED 3-3-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-6-50.	24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	24D. LOCATION (City, town, or county) (State) 4701 German Hill Rd. Balto Co.
DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950		25. FUNERAL DIRECTOR John S. Zeiler ADDRESS 901 S. Conkling St.	



550
50 1883BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1883

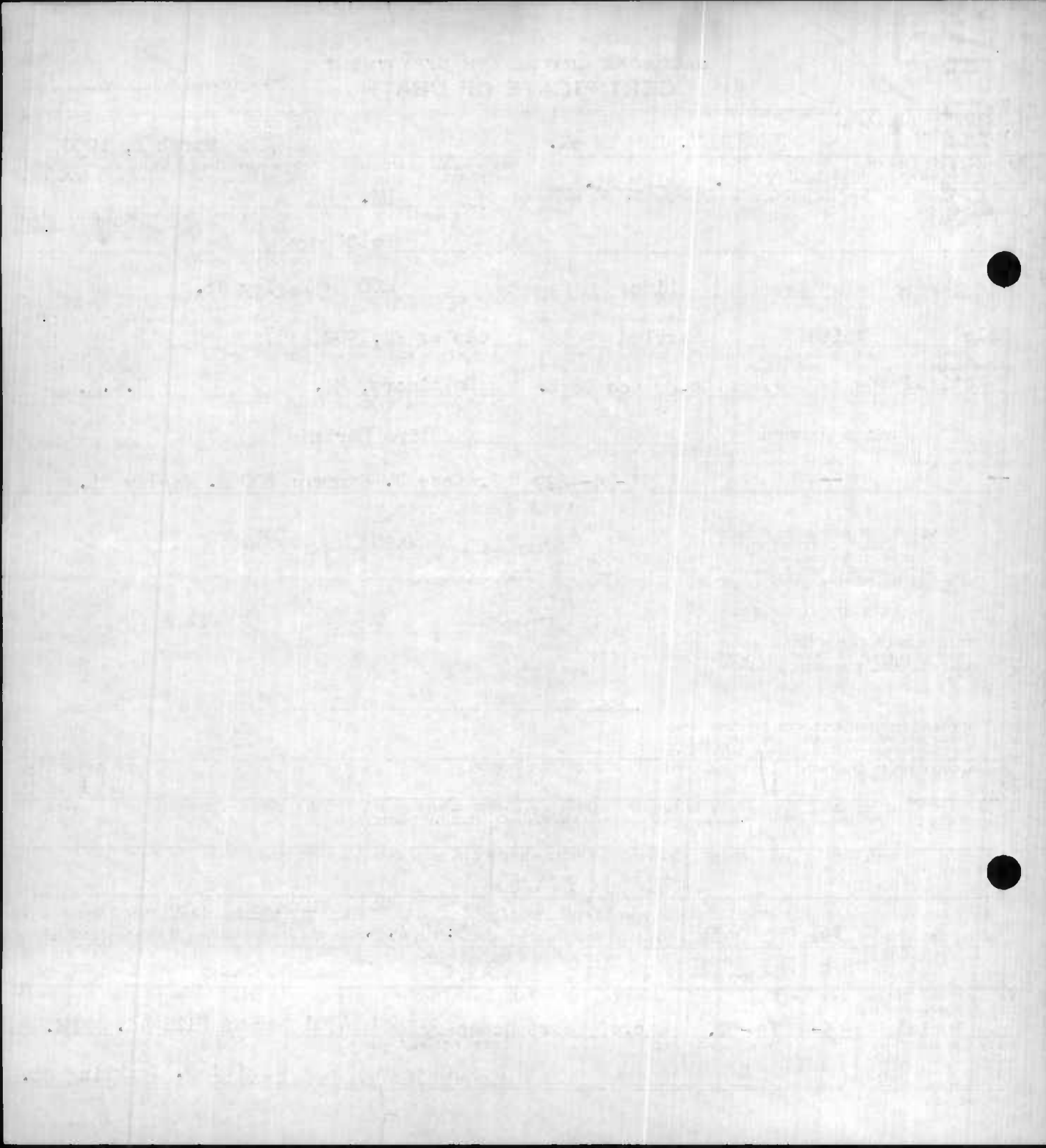
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE V. HAMMEN SR.		2. DATE OF DEATH March 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 800 S. Fagley St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-09	
C. Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 800 S/ Fagley St.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH October 22, 1902
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman Balto. Police Dept.		9. AGE (In years last birthday) 47	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
13. FATHER'S NAME George Hammen		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, on or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-24-9829	17. INFORMANT ADDRESS Frances J. Hammen: 800 S. Fagley St.

18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary artery thrombosis & occlusion. DUE TO (A) Coronary artery disease. DUE TO (B) DUE TO (C)	CAUSE OF DEATH Coronary artery thrombosis & occlusion. Coronary artery disease.	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 10 , 19 46 , to Dec 1 , 19 50 , that I last saw the deceased alive on Feb 20 , 19 50 , and that death occurred at 5:45 A.M. from the causes and on the date stated above.					
23A. SIGNATURE Ea Fleming Jr M. D.		23B. ADDRESS 3503 East Ave		23C. DATE SIGNED 3-2-50-	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-4-50.	24C. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	24D. LOCATION (City, town, or county) (State) 4701 German Hill Rd. Md.		
DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950	REGISTRAR'S SIGNATURE Walter J. Williams	25. FUNERAL DIRECTOR ADDRESS Charles S. Zeiler 901 S. Conkling St.			



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1884
Registered No. _____

BIRTH NO. 50 1884

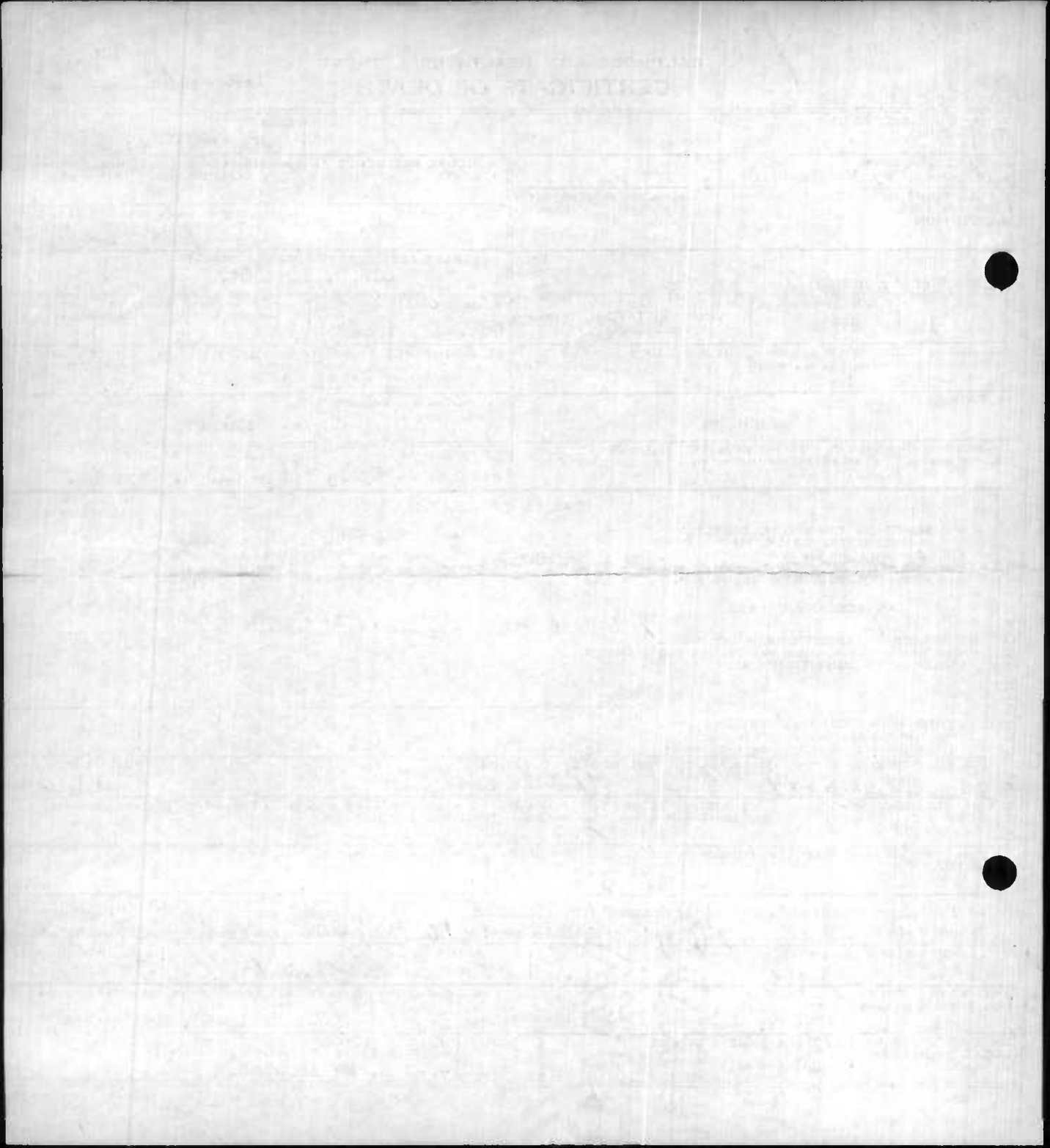
1. NAME OF DECEASED (Type or Print) MARY HYZA		2. DATE OF DEATH March 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 815 N. Port St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
Length of stay in Baltimore 45 years		D. STREET ADDRESS (If rural, give location) 815 N. Port St.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 11, 1881
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) 68
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Joseph J. Hyza, son - 815 N. Port St.		ADDRESS _____	

18. I 151X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalized Carcinomatosis DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Car. of Stomach DUE TO _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____		

19A. DATE OF OPERATION June 25-49		19B. MAJOR FINDINGS OF OPERATION Ca Stomach		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from 12-20 , 19 49 , to 3-1 , 19 50 , that I last saw the deceased alive on 3-1 , 19 50 , and that death occurred at 10 Pm. , from the causes and on the date stated above.					
23A. SIGNATURE L. T. Ford Jr.		23B. ADDRESS 2601 E. Madison St.		23C. DATE SIGNED 3-2-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE March 4, 1950		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. FUNERAL DIRECTOR Schimmek Funeral Home, Inc.		24F. ADDRESS 2601-3-5 E. Madison St.	

MAR 3 - 1950

46B



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1885

Registered No. _____

BIRTH NO. 50 1885

1. NAME OF DECEASED (Type or Print) JOSEPH WENCESLAUS VONASEK S r.,		2. DATE OF DEATH March 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 724 N. Port St.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-02	
D. STREET ADDRESS (If rural, give location) 724 N. Port St.			
5. LENGTH OF STAY IN BALTIMORE 38 years		Yrs. Mos. Days	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct. 19, 1891
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired bricklayer		10B. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years; last birthday) 58
11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Vonasek		14. MOTHER'S MAIDEN NAME Josephine Kozelouzek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. 216-09-0070	
17. INFORMANT ADDRESS Mrs. Frances Vonasek, 724 N. Port St.			

<p>18. 421.4</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>CAUSE OF DEATH</p>		<p>INTERVAL BETWEEN ONSET AND DEATH</p>
	<p>(A) Cerebral Hemorrhage</p> <p>DUE TO</p>		<p>Feb 23-50</p>
	<p>(B) Chronic Valvular Heart Trouble</p> <p>DUE TO</p>		<p>Jan 1 1945</p>
	<p>(C) Generalized Arterio Sclerosis</p>		<p>Jan 1 1948</p>

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from Jan 1, 1950 , to March 1, 1950 , that I last saw the deceased alive on March 1, 1950 , and that death occurred at 34 M. , from the causes and on the date stated above.					
23A. SIGNATURE William J. Rydner M. D.		23B. ADDRESS 801 E. Newwood Ave		23C. DATE SIGNED 3/2/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE March 4, 1950		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
DATE RECEIVED BY LOCAL REGISTRAR MAR 5 - 1950		REGISTRAR'S SIGNATURE William J. Rydner		25. FUNERAL DIRECTOR ADDRESS Schmuneke Funeral Home, Inc. 2601-325 E. Madison St.	

306 V9

93D

correct age is especially important. Infections, please state the cause of death clearly and briefly.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

STATE OF NEW YORK

IN SENATE

January 1, 1900

Attest:

Secretary of State

Albany, N. Y.

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50 1886

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1886

Registered No. _____

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		ELIJAH J. BANKS		2-27-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 1620 E. Biddle Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-07			
Length of stay in Baltimore 18 Mos. Days		D. STREET ADDRESS (If rural, give location) 1620 E. Biddle Street			
5. SEX male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 2-2-1877	9. AGE (In years last birthday) 73	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Saluda, Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Gabriel Banks		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Estelle Tillman 1620 E. Biddle St.	
18. 177X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Urinary Infection Urinary Retention Hypertrophied Prostate (B) Carcinoma - prostate gland (C) Intest. Insufficiency and general debility Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Interval between onset and death 2 wks 1 yr. (over)					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 1, 1950, to Feb 27, 1950, that I last saw the deceased alive on Feb 26, 1950, and that death occurred at 11:40 P. M., from the causes and on the date stated above.					
23A. SIGNATURE Ralph J. Young		23B. ADDRESS M. P. 1424 E. Monument St		23C. DATE SIGNED 3/1/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE 3-4-1950		24C. NAME OF CEMETERY OR CREMATORY Grafton	
24D. LOCATION (City, town, or county) (State) Lopings, Middlesex Co. Va.		24E. FUNERAL DIRECTOR Randolph J. Collick		24F. ADDRESS 1532 E. Biddle St.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	

MEDICAL CERTIFICATION

correct age is especially important. If physicians, please write the cause of death clearly and legibly.

866VV

51B

See Document File 50-1886

4-19-50

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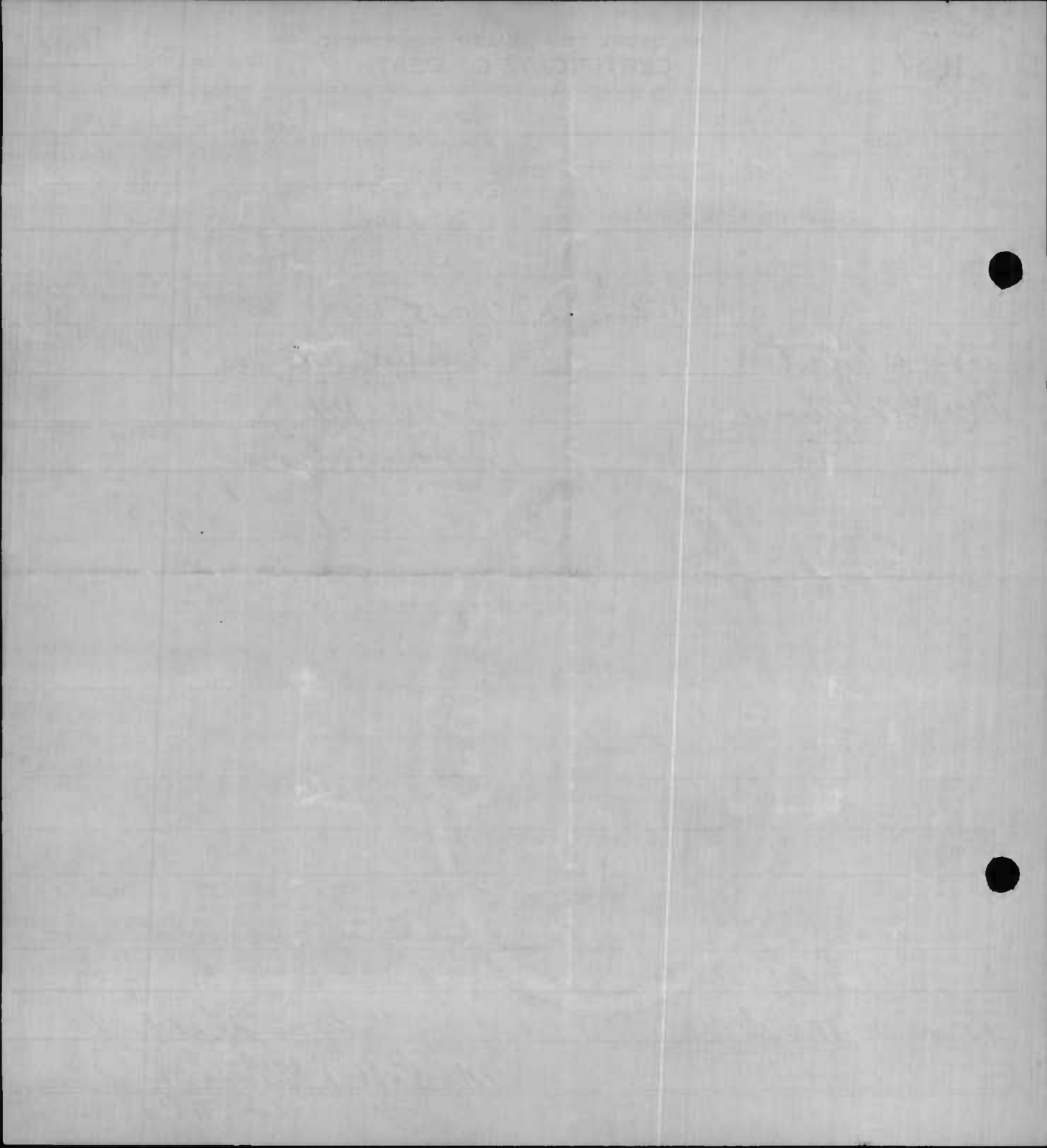
535
30 1887
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1887
Registered No.

1. NAME OF DECEASED (Type or Print)		WILLIAM		ANTHONY		2. DATE OF DEATH March 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
B. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital				A. STATE Maryland		B. COUNTY	
Length of stay in Baltimore				C. CITY OR TOWN Baltimore		(If outside corporate limits, write RURAL and give township)	
D. STREET ADDRESS (If rural, give location) 815 N. Wolfe Street				E. AGE (In years last birthday) 65		F. Under 1 Year Months: Days: Hours: Min.	
5. SEX Male		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower		8. DATE OF BIRTH Nov 25, 1884	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed				10B. KIND OF BUSINESS OR INDUSTRY FARMER - SEED		11. BIRTHPLACE (State or foreign country) Islewhite Co Va.	
13. FATHER'S NAME Oscar Anthony				14. MOTHER'S MAIDEN NAME Amy Hill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT John Anthony		ADDRESS	
18. 434.3 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cor Pulmonale				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Emphysema							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
23A. SIGNATURE Mr. J. Mc Clafferty				23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 3-2-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal		24B. DATE March 4/50		24C. NAME OF CEMETERY OR CREMATORY Smithfield Va		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR MAR 3 - 1950		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR Mrs. R. G. White & Daughter		ADDRESS	

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140
50 1888BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1888

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Indie Chappel

2. DATE
OF
DEATH

Jul 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1140 E. Lombard St

C. Length of stay in Baltimore

25 yrs

Yrs.
Mos.
Days

5. SEX

7

6. COLOR OR RACE

C.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

13. FATHER'S NAME

Eaton Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

8. DATE OF BIRTH

Oct 19, 1890

9. AGE (In years
last birthday)

60

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Demetria County Va.

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Bettie Rose

17. INFORMANT

ADDRESS

Estella Robinson 1140 E Lombard St

18. 442.X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Chronic Cardio-renal
vascular disease

6 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertension

8 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐
WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 10, 1949, to Feb 28, 1950, that I last saw the deceased alive on Feb 28, 1950 and that death occurred at 2:30 p.m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

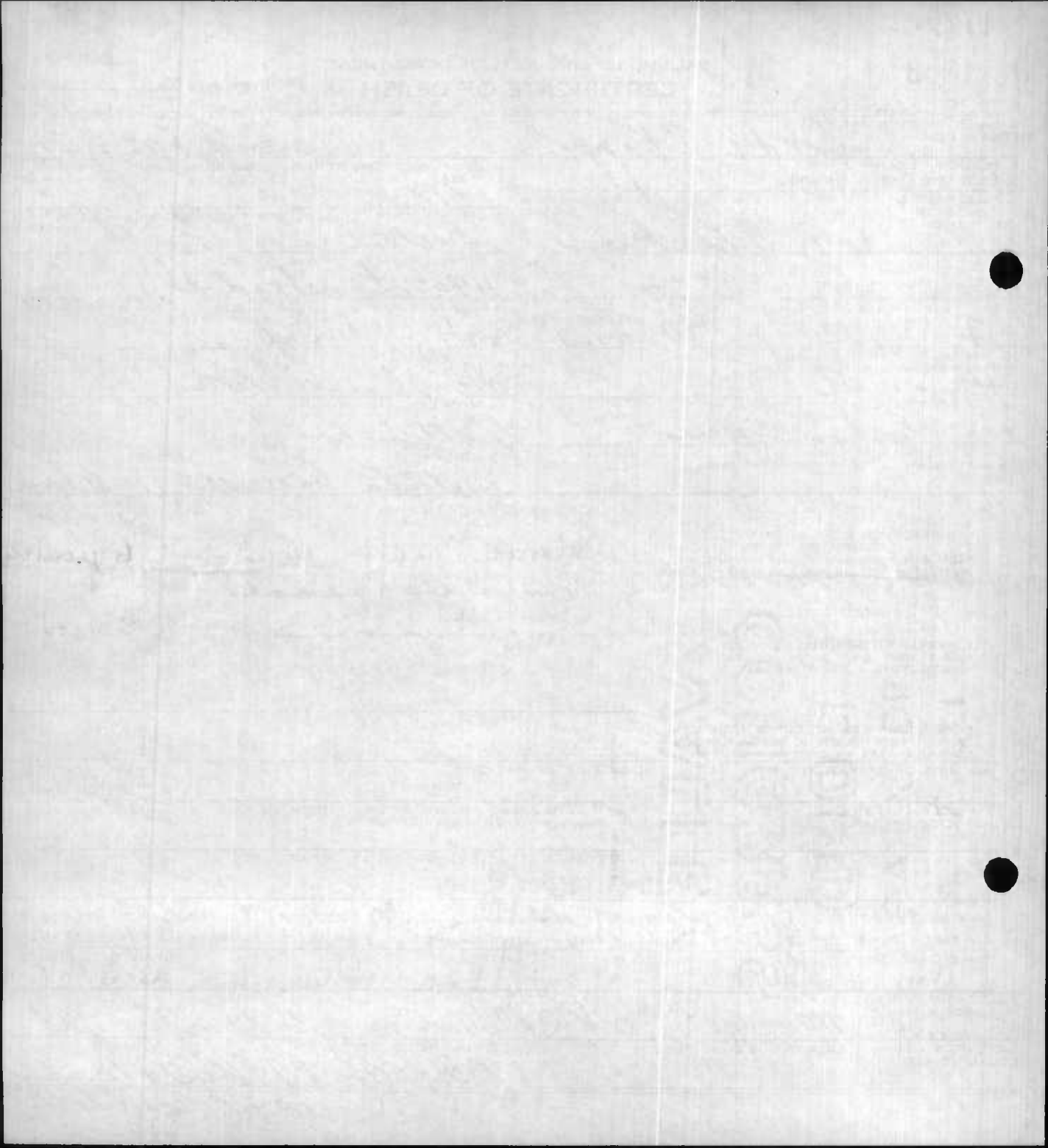
(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



200
50 1889Peck
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓

50 1889

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Hester Jeran Peck

2. DATE
OF
DEATH

3-2-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1319- Madison Av.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

1612-W-Lafayette Av.

D. STREET ADDRESS (If rural, give location)

1612-W-Lafayette Av.

C. Length of stay in Baltimore

65

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,
last birthday)10. Under 1 Year
Months: Days
11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Nathanial T. Peck

18. 442 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Cardio-Vascular-Renal

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Disease-Hypertensive

DUE TO

1 year

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-15-1949 to 3-2-1950, that I last saw the deceased alive on 3-2-1950, and that death occurred at 7:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR
MAR 3 - 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Robert G. Elliott & Dy.
1129 N. Caroline St.
131a

VALLEY
COLLEGE PRESS

BOOKS

1004 MAC

U S A

300

50 1890

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1890

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary Scott

2. DATE
OF
DEATH

March 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1715 Maryland Ave

B. FULL NAME OF (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Fe.

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Maid

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

Aug. 14, 1900

9. AGE (In years last birthday)

49

11. BIRTHPLACE (State or foreign country)

Floater County Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

yes, give war or dates of service

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

William E Scott 1715 Maryland Ave

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Essential Hypertension

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3/2/50

19B. MAJOR FINDINGS OF OPERATION

Lumbar Puncture; Veresection

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/2/1950, to 3/2/1950 that I last saw the deceased alive on 3/2/1950, and that death occurred at 10:55 AM, from the causes and on the date stated above.

23A. SIGNATURE

Maddens Blumiski

M. D.

23B. ADDRESS

1400 N. Caroline Street

23C. DATE SIGNED

3/2/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

March 4/50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Am

24D. LOCATION (City, town, or county)

G. G. County Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Peter A. Elliott, Dugout

VS 150

52086

1129 N. Caroline St. 83a

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

STATE OF NEW YORK

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

50 1891

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1891

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)*Marie (Maria) Smith*2. DATE
OF
DEATH*March 2/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 12-05
415 E Lafayette Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION

415 E Lafayette Ave.

C. Length of stay in Baltimore

*50 yrs*Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Dec 12, 1860

9. AGE (In years last birthday)

89

10. Under 1 Year

11. Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Edward Smith

14. MOTHER'S MAIDEN NAME

Betty Benkey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Marie Saunders 922 Leaden*18. *4/22/1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

1 year

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary Vascular Disease*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)
DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 15, 1950* to *March 2, 1950*, that I last saw the deceased alive on *March 2, 1950*, and that death occurred at *2 P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial**March 6/50**mt Calvary Cem**99 County Md*

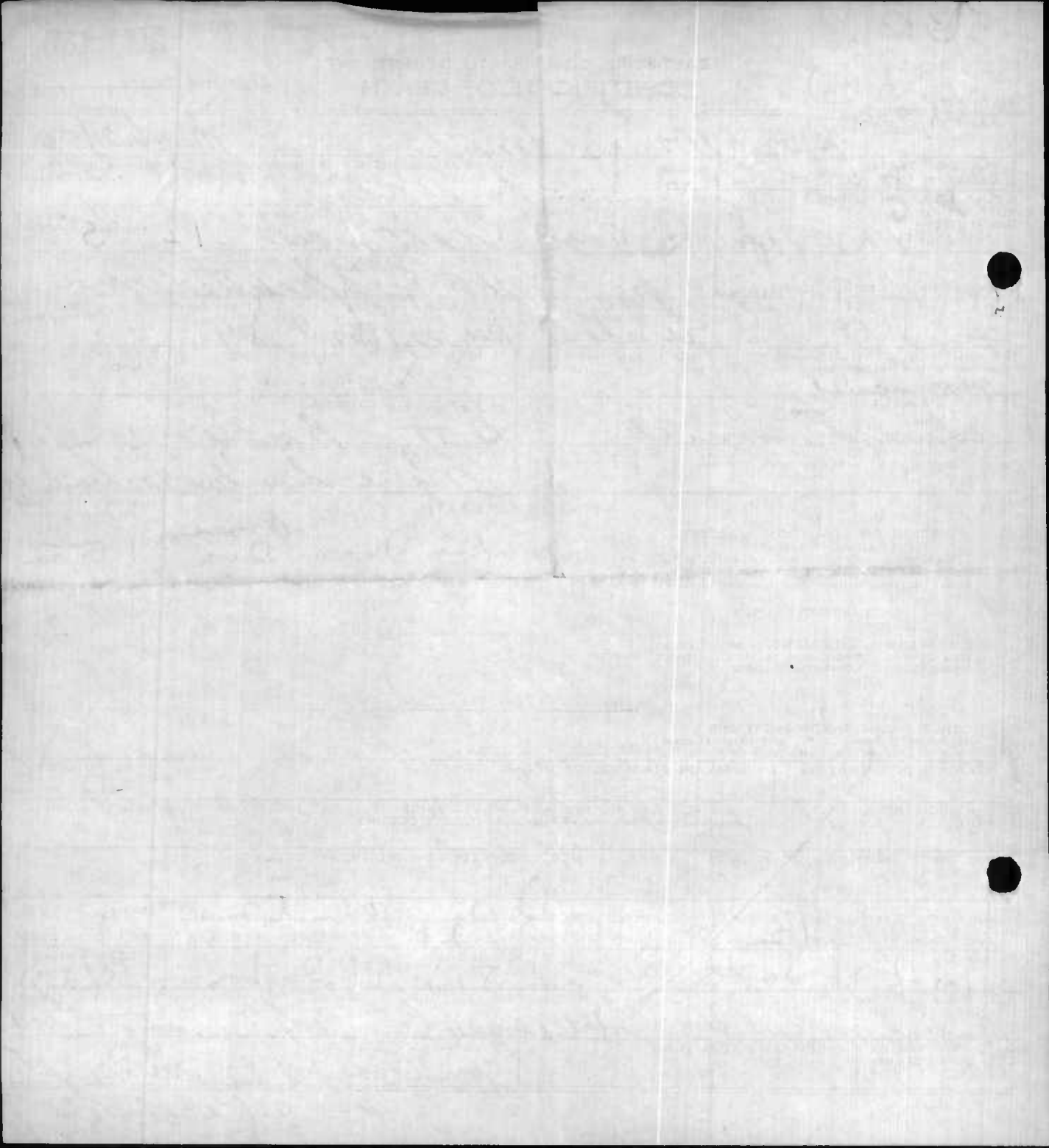
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*MAR 3 - 1950**Wm. J. Williams**Wm. Robert A. Elliott & Daughter**1129 N. Carling St 938*



T-520

Jl-135620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1892
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Frank Thomas

2. DATE
OF
DEATH

2-9-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)Baltimore City Hospitals
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Md.

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

7027 N. Caroline St.
Crownsville State Hospitals, A.A. Co.

5. SEX

Male

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 16, 1889

9. AGE (in years
last birthday)

60

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Thomas

14. MOTHER'S MAIDEN NAME

Maryann Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL

SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18. 570.5

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary Embolus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Intestinal Obstruction

19A. DATE OF OPERATION

Feb. 9, 1950

19B. MAJOR FINDINGS OF OPERATION

Intestinal Obstruction

20. AUTOPSY?

YES ☐ No ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 8, 1950 to Feb. 9, 1950, that I last saw the
deceased alive on Feb. 9, 1950, and that death occurred at 7.55 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

2-22-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL FEB 28 1950

Commissioner of Health

To be approved by Medical Examiner.

VS 150

122B

MEDICAL CERTIFICATION

NOT A MEDICAL EXAMINER'S CASE

RS Fisher

M.D.

CHIEF OF ASS'T. MEDICAL EXAMINER

C-620
50 1893BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1893

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Samuel Augustus Craig

2. DATE
OF
DEATH

3/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

2206 Pelham Avenue

59 Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2206 Pelham Avenue

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

2/18/91

9. AGE (in years
last birthday)

59

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Contractor

10B. KIND OF BUSINESS OR
INDUSTRY

Tile & Marble

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Samuel Augustus Craig

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Catherine Craig 2206 Pelham

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1/50 to 3/2/50, 1950, that I last saw the
deceased alive on 3/1/50 and that death occurred at 1:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Thomas J. White, M.D.

23B. ADDRESS

3809 Germantown Ave

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/4/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

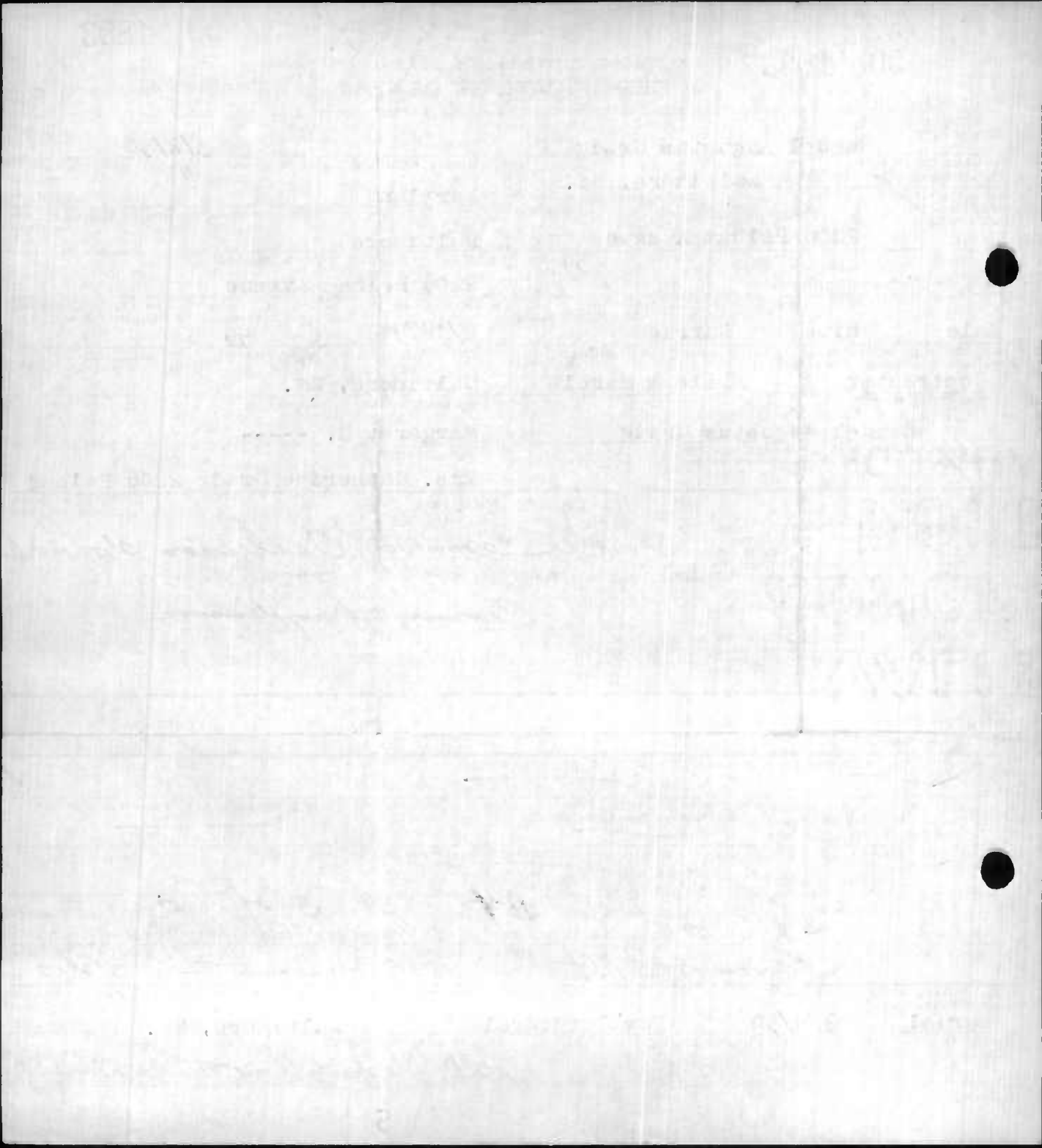
ADDRESS

W. B. Means and Son 805 N. Calvert St.

MAR 3 1950

156601805

94a



W 452
50 1894BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1894
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

George W. Milling

2. DATE
OF
DEATH

MAR 3 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

C. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

Salisbury

D. STREET ADDRESS (If rural, give location)

119 Truitt St

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

5-11-49

9. AGE (In years
last birthday)If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.

10 22

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George W. Milling

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 1934

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Brain Tumor

DUE TO

in the posterior fossa, malignant

over

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from 2-27-1950, to 3-3-1950, that I last saw the deceased alive on 3-3-1950, and that death occurred at 6:00 a.m., from the causes and on the date stated above.

23A. SIGNATURE

James Gamble

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

March 5-1950

24C. NAME OF CEMETERY OR CREMATORY

Parsons Cem

24D. LOCATION (City, town, or county)

Salisbury

(State)

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Holloway & Co Salisbury Md.

MAR 3 - 1950
VS 150

54 B

Letter in document file 50-1894 4/10/50

650
50 1895

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1895
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR J. BROWN.

2. DATE
OF
DEATH

3/3/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

University of Maryland Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution; residence

A. STATE

B. COUNTY

before admission)

Maryland.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE 26-03

D. STREET ADDRESS (If rural, give location)

3226 Pelham Ave

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married.

8. DATE OF BIRTH

Jan. 31 1877

9. AGE (In years,
last birthday)

73

10. Under 1 Year
Months: Days

1 3

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Retired Boilermaker

10B. KIND OF BUSINESS OR
INDUSTRY

Mach. Dep. Erie R.R.

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

John Brown

14. MOTHER'S MAIDEN NAME

Mary Hawkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Suzanne - Same

18. 600.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Perforation of Pyloric Ulcer, Patena

DUE TO

left.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Pyonephrosis & Perinephric abscess

DUE TO

(C) arteriosclerotic C-v. disease.

Diabetes Mellitus

15 yrs.

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3/1/50

19B. MAJOR FINDINGS OF OPERATION

Pyonephrosis, left, perinephric abscess, left.

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 2/4, 1950, to 3/3, 1950 that I last saw the
deceased alive on 3/3, 1950, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Mark E. Wall, Jr.

M. D.

23B. ADDRESS

2107 N. W. 4th St.

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

BURIAL

MARCH-6-50

MECUNES-CEMETERY

SUSQUEHANNA PA

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

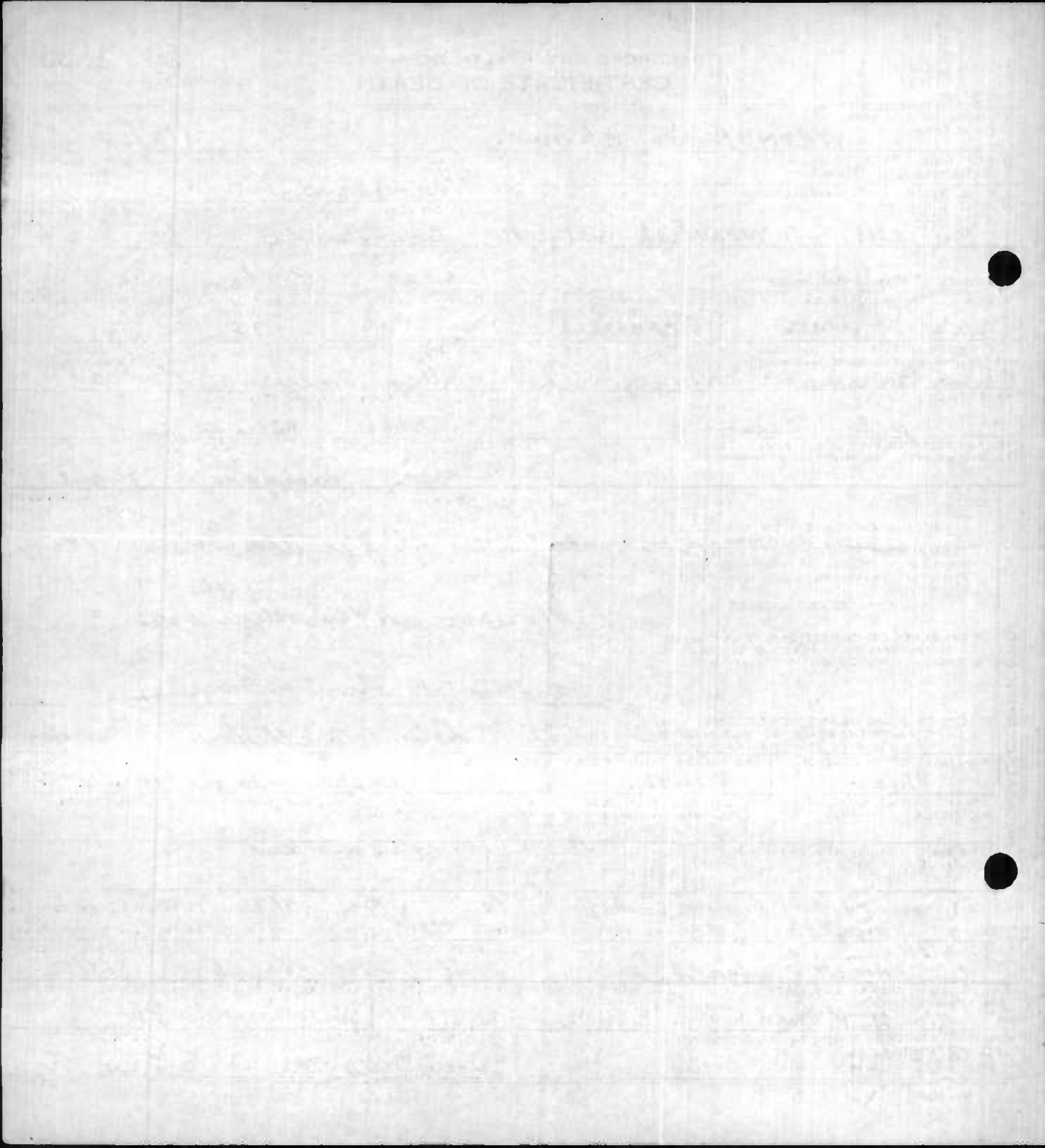
25. FUNERAL DIRECTOR

ADDRESS

MAR 4 - 1950

W. H. Williams, Jr.

Frank Della Woe 322 S. HIGH ST.



200
50 1896

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1896

Registered No. _____

1. NAME OF DECEASED (Type or Print) <i>ELEANOR HOG</i>		2. DATE OF DEATH <i>May 3, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>New Jersey</i> B. COUNTY <i>Essex</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hosp</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Tenafly</i>	
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>142 Windsor Road</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Jan 26, 1893</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Statistician</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	
9. AGE (In years last birthday) <i>57</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Alphonse Alois (ALAIRE)</i>	
14. MOTHER'S MAIDEN NAME <i>Anna Maynette</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>RF</i>	
ADDRESS			

18. <i>170 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Carcinomatosis</i> (A) _____ DUE TO	CAUSE OF DEATH <i>Carcinomatosis</i> (B) <i>Carcinoma of rt. breast</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>1 mo</i> <i>10 mo</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>None</i>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2/2</i> , 19 <i>50</i> , to <i>3/3</i> , 19 <i>50</i> , that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Ernest P. Inglis</i>		23B. ADDRESS <i>142 Windsor Road</i>		23C. DATE SIGNED <i>3/3/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Funeral</i>		24B. DATE <i>3/4/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Brookside</i>	
24D. LOCATION (City, town or county) <i>Englewood</i>		24E. LOCATION (State) <i>MD</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 4 - 1950</i>		REGISTRAR'S SIGNATURE <i>William</i>		25. FUNERAL DIRECTOR <i>William</i>	
ADDRESS					

V5293

50

correct age is especially important. Physicians, please write the causes of death clearly and legibly.

STATE OF NEW YORK
CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

GRANDCHILDREN

GRANDPARENTS

OTHER RELATIVES

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

CITY OF BIRTH

COUNTY OF BIRTH

STATE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

GRANDCHILDREN

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50 1897**

1. NAME OF DECEASED

(Type or Print) **WILLIE**

SELLERS

2. DATE

OF DEATH **March 3, 1950**

3. PLACE OF DEATH:

A. **Baltimore City, Maryland**

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

O. STREET ADDRESS (If rural, give location)

2916 Elliott Street

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

10/8/1945

9. AGE (in years last birthday)

4

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Black Ala.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

William Sellers

14. MOTHER'S MAIDEN NAME

Charlotte L. Waters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT **Charlotte L. Sellers Elliott st**

18. **353.2 I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Status epilepticus**
DUE TO **idiopathic epilepsy**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....☒

23C. DATE SIGNED

ASSISTANT MEDICAL EXAMINER.....☐

March 3, 1950

M.D. MEDICAL INVESTIGATOR.....☐

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peters

24D. LOCATION (City, town, or county)

Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Sellers

25. FUNERAL DIRECTOR

ADDRESS

Wm. Cook Inc., 1217 St. Paul St.

MAR 4 - 1950

CERTIFICATE OF DEATH

State of New York

County of _____

City of _____

On this _____ day of _____

460
50 1898
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1898
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Donzella Tyler</i>		2. DATE OF DEATH <i>3/1/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>1301 Northview Rd</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. 27-09</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1301 Northview Rd - Northwood</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>7/21/1881</i>
9. AGE (in years last birthday) <i>68</i>		10. UNDER 1 Year Months: Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George T. Smith</i>		14. MOTHER'S MAIDEN NAME <i>Rebecca</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Evelyn Haller</i>		ADDRESS <i>1301 Northview Rd</i>	

18. <i>4222</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Myocarditis</i> DUE TO (A)	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Acute postoperative</i>		<i>4 days</i>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb 27*, 19*50*, to *March 1*, 19*50* that I last saw the deceased alive on *Feb 28*, 19*50*, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE
Wm J. Klemm

23b. ADDRESS
701 N. Kanawood Ave.

23c. DATE SIGNED
3/5/50

24a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24b. DATE
3/4/50

24c. NAME OF CEMETERY OR CREMATORY
Balto.

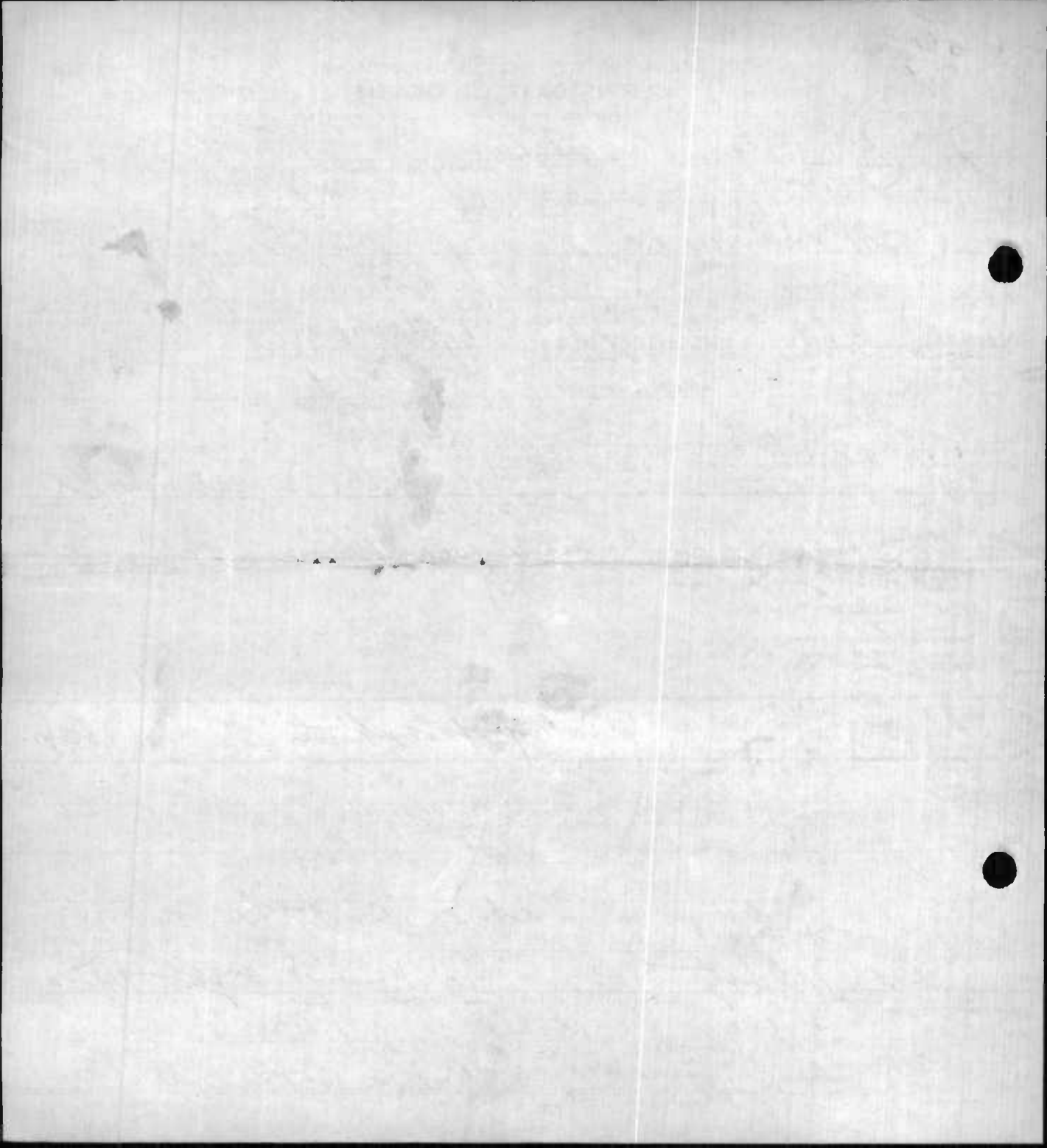
24d. LOCATION (City, town, or county) (State)
Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR
MAR 4 - 1950

REGISTRAR'S SIGNATURE
Wm J. Klemm

25. FUNERAL DIRECTOR
Wm Cook, Inc.

ADDRESS
1217 St Paul st.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1899
Registered No. _____

300
50 1899
BIRTH NO. _____

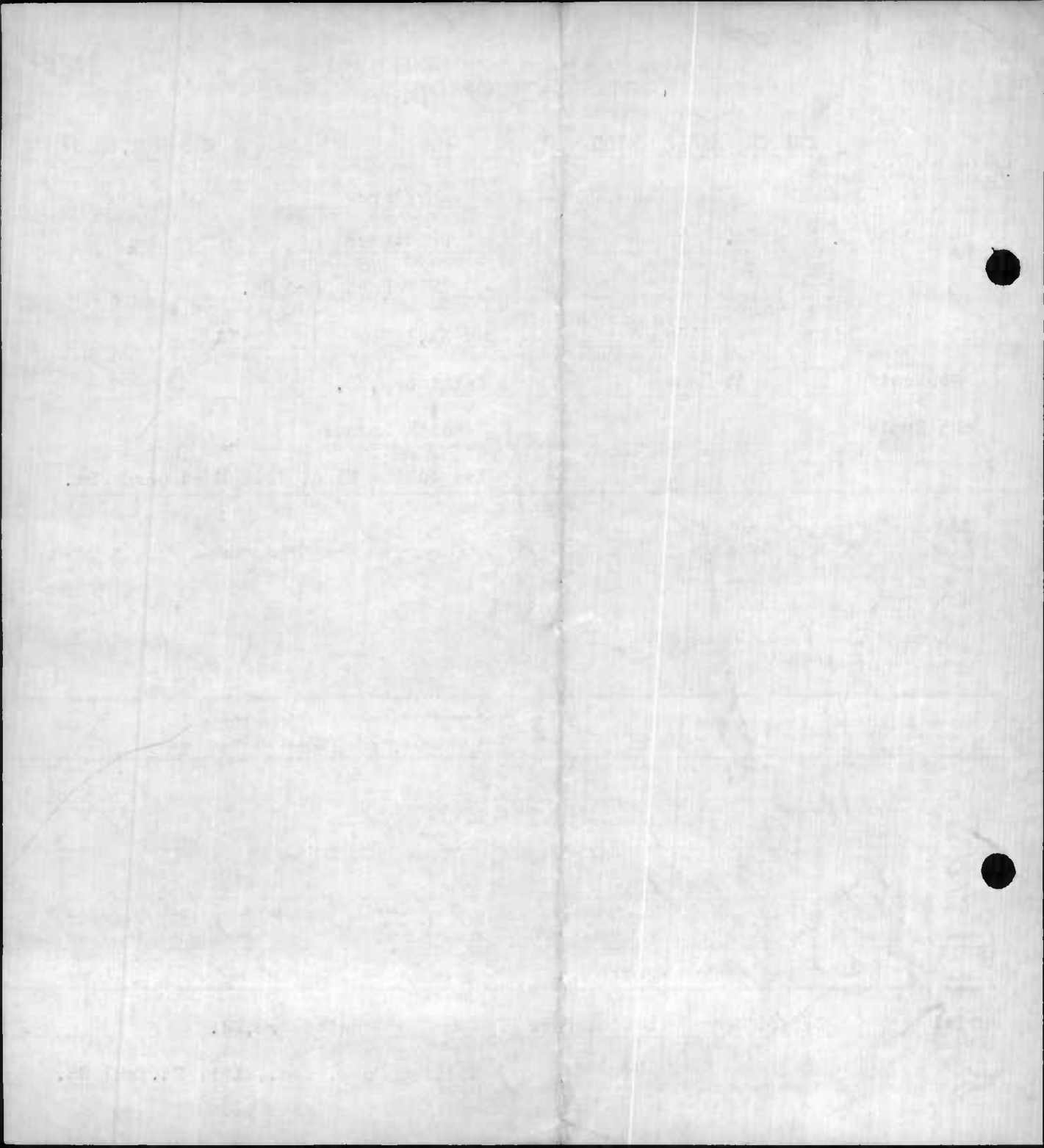
1. NAME OF DECEASED (Type or Print) JUDITH MARIE KIDD		2. DATE OF DEATH March 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1817 E. 33rd St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) 1817 East 33rd St.	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH May 31, 1973
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE (In years last birthday) 73 If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____
13. FATHER'S NAME John Epple		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		12. CITIZEN OF WHAT COUNTRY? _____	
16. SOCIAL SECURITY NO. _____		14. MOTHER'S MAIDEN NAME Judith Lorenz	
17. INFORMANT Miss Judith Kidd, 1817 East 33rd St.		ADDRESS _____	

18. 151X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
(A) Carcinoma of Stomach DUE TO		
(B) _____ DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ① Chv. Rheumatoid arthritis ② Cardiovascular heart disease		

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) _____ OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from Dec. 10, 1946 , to Mar. 2, 1950 , that I last saw the deceased alive on Mar. 1, 1950 , and that death occurred at 11:45 a.m., from the causes and on the date stated above.					
23A. SIGNATURE George Sauer		23B. ADDRESS 4868 Harford Rd.		23C. DATE SIGNED 3/3/50	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/6/50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 4 - 1950		REGISTRAR'S SIGNATURE William Cook, Inc.		25. FUNERAL DIRECTOR William Cook, Inc., 1217 St. Paul St.		ADDRESS _____	

MEDICAL CERTIFICATION



CERTIFICATE CORRECTED BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 1900

Registered No. _____

BIRTH NO _____

1. NAME OF DECEASED (Type or Print) LEONARD FORRESTER		2. DATE OF DEATH March 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-02	
D. STREET ADDRESS (If rural, give location) 622 Portland Street		E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JULY 15, 1875
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CITY	9. AGE (In years last birthday) 74 73 If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
13. FATHER'S NAME LEONARD FORRESTER		11. BIRTHPLACE (State or foreign country) MARYLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? _____	
16. SOCIAL SECURITY NO. _____		14. MOTHER'S MAIDEN NAME HARRIET GABLE	
17. INFORMANT MRS. LOTTIE MEREDITH		ADDRESS 2252 SIDNEY AVE.	

18. 470.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CORONARY ARTERY DISEASE DUE TO (A) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ARTEROSCLEROSIS DUE TO (B) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____	INTERVAL BETWEEN ONSET AND DEATH _____
--	---

19A. DATE OF OPERATION _____	19B. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____

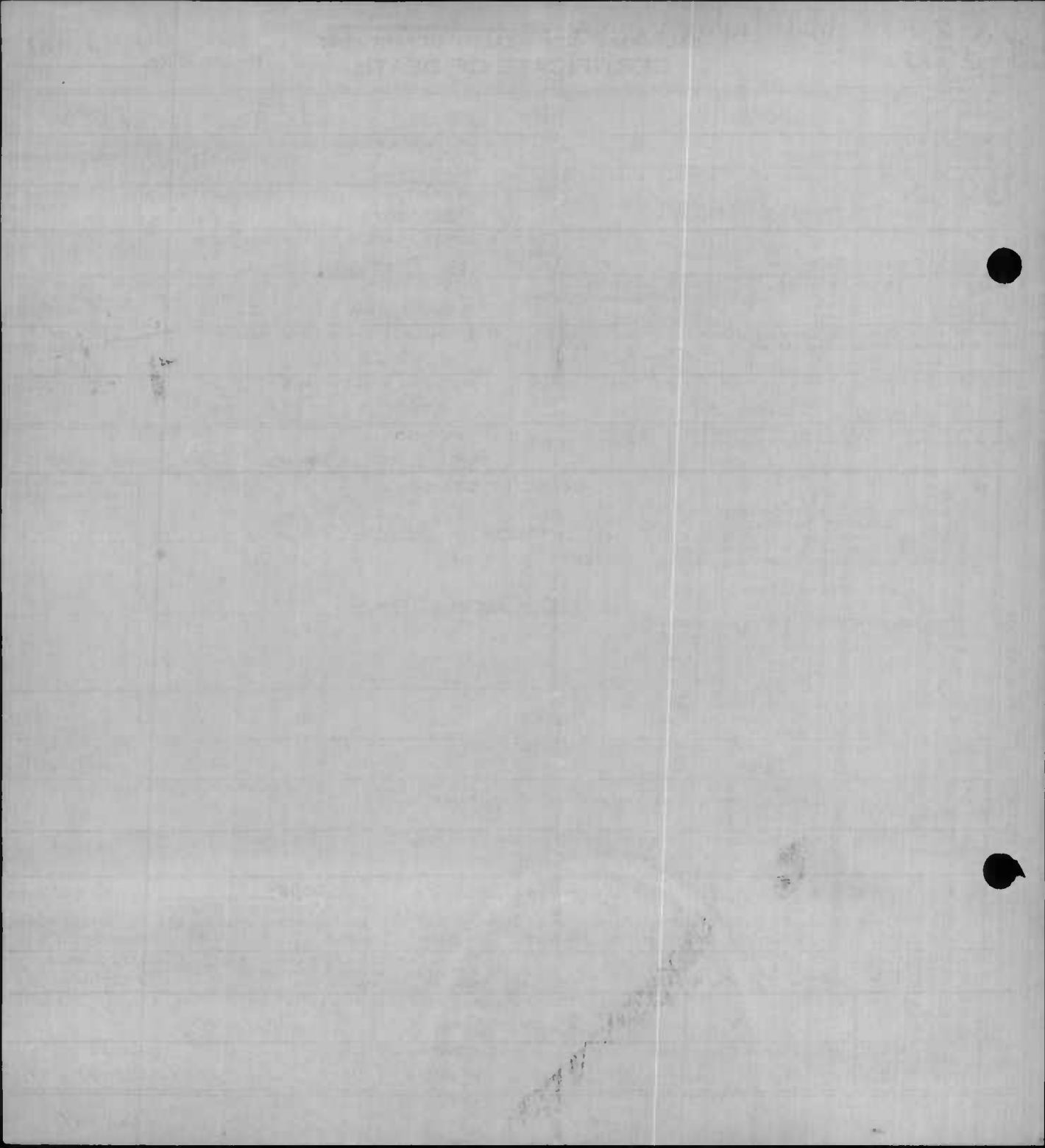
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE H. J. Mc Clafferty	23B. CHIEF MEDICAL EXAMINER _____ ASSISTANT MEDICAL EXAMINER _____ MEDICAL INVESTIGATOR _____	23C. DATE SIGNED 3-3-50
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3/4/50	24C. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM
24D. LOCATION (City, town, or county) (State) FREDERICK RD.	25. FUNERAL DIRECTOR JOHN F. DENNY, INC	
DATE RECEIVED BY LOCAL REGISTRAR MAR 4 - 1950		ADDRESS 715 LIGAT ST. - 30

98898

94a ✓

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1901

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

EDWARD

KAROPCHINSKY

2. DATE
OF
DEATH

March 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (if rural, give location)

1614 Cherry Street

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct 1911

9. AGE (In years last birthday)

39

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cabaret

10B. KIND OF BUSINESS OR INDUSTRY

CLOTHING FACTORY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Peter Karopchinski

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216059901

17. INFORMANT

ADDRESS

Stices 1614 Cherry St.

18. E903.5

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Subdural hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Fracture, skull

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic alcoholism

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Alley

21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Alley alongside of 4710 Curtis Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

3-2-50 12:30 P.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stumbled and fell to ground

2515

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

H. J. Mc Clafferty

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

3-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

March 6/50

24C. NAME OF CEMETERY OR CREMATORY

Holy Trinity

24D. LOCATION (City, town, or county) (State)

Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR

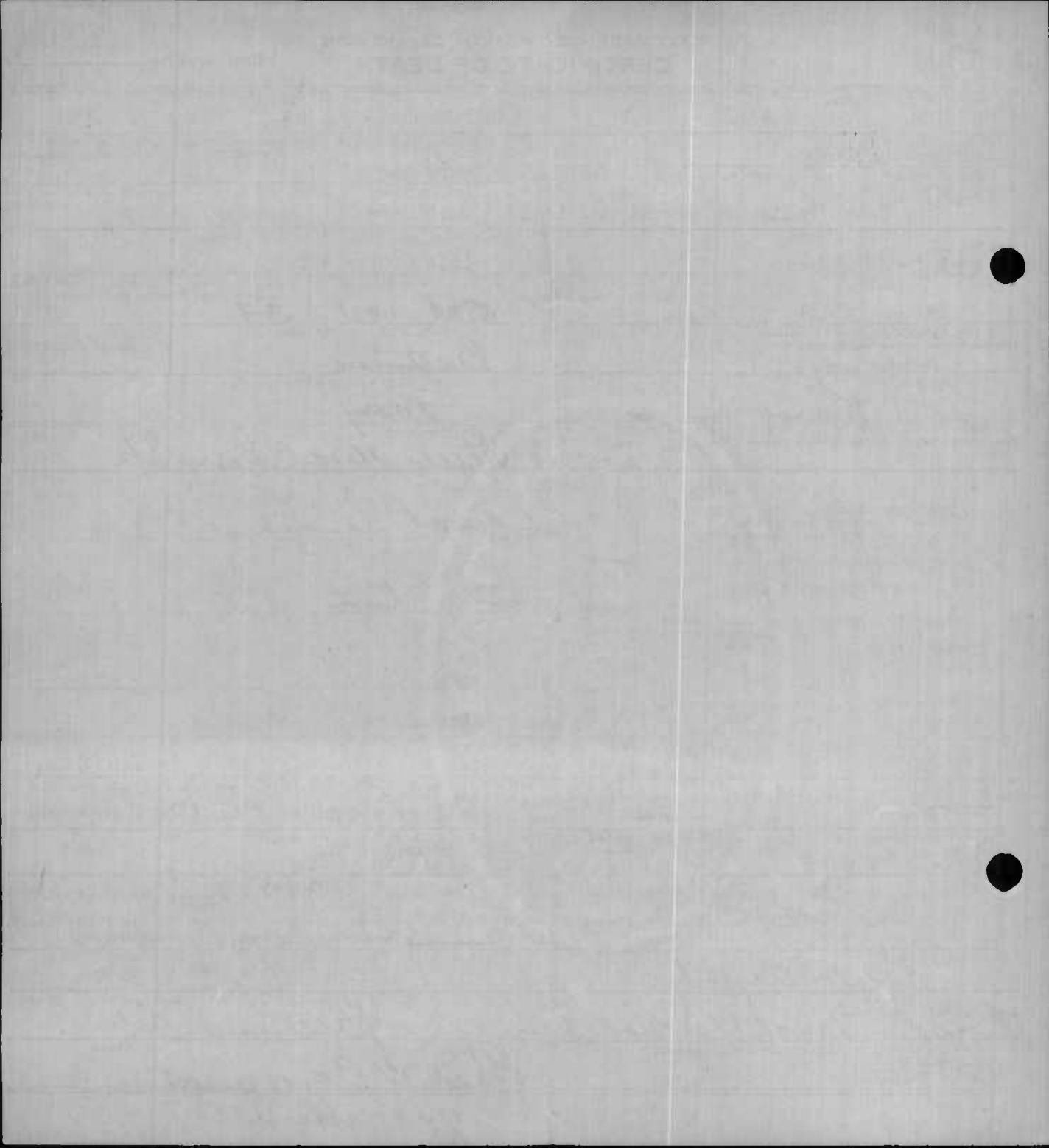
MAR 4 - 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Fred W. Ozaszewski



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1902

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Einer Jensen

2. DATE
OF
DEATH

March 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1620 Shakespeare St

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

6-2-96

9. AGE (In years
last birthday)

53

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Heavy Bldg.

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Denmark

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Pete Jensen

14. MOTHER'S MAIDEN NAME

Marie?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 581.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Laennec's Cirrhosis

11 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/9, 1944, to 3/2, 1950, that I last saw the deceased alive on 3/2, 1950, and that death occurred at 7:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert C. Hartmann, M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

3/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 4 - 1950

Fred W. Ozaszewski

1950

Easton, Md.

VS 150

1050 988871004

124a

MEDICAL CERTIFICATION
correct age is especially important. Physicians, please write the cause of death clearly and legibly.

100

100

100

100

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1903

Registered No. _____

BIRTH NO. 1903 50-04646

1. NAME OF DECEASED (Type or Print) Keiffer, Baby Girl		2. DATE OF DEATH March 3, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balt.	
B. FULL NAME OF HOSPITAL OR NURSING HOME St. Joseph's		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 556 Edgewater Apt.			
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 3, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME Arthur Burke Keiffer		14. MOTHER'S MAIDEN NAME Lucille Kotokowski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. _____	
17. INFORMANT _____		ADDRESS _____	

18. 776.X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Prematurity		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (A) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____		
DUE TO (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from March 3, 1950 to March 3, 1950 , that I last saw the deceased alive on March 3, 1950 , and that death occurred at 6:00 P. m. , from the causes and on the date stated above.					
23A. SIGNATURE Vito S. Coppa		23B. ADDRESS M. D. 1100 N. Caroline St.		23C. DATE SIGNED March 3, 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-4-50		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem	
24D. LOCATION (City, town, or county) Balta County		24E. FUNERAL DIRECTOR John M. Weber		24F. ADDRESS 401 S. Chester	

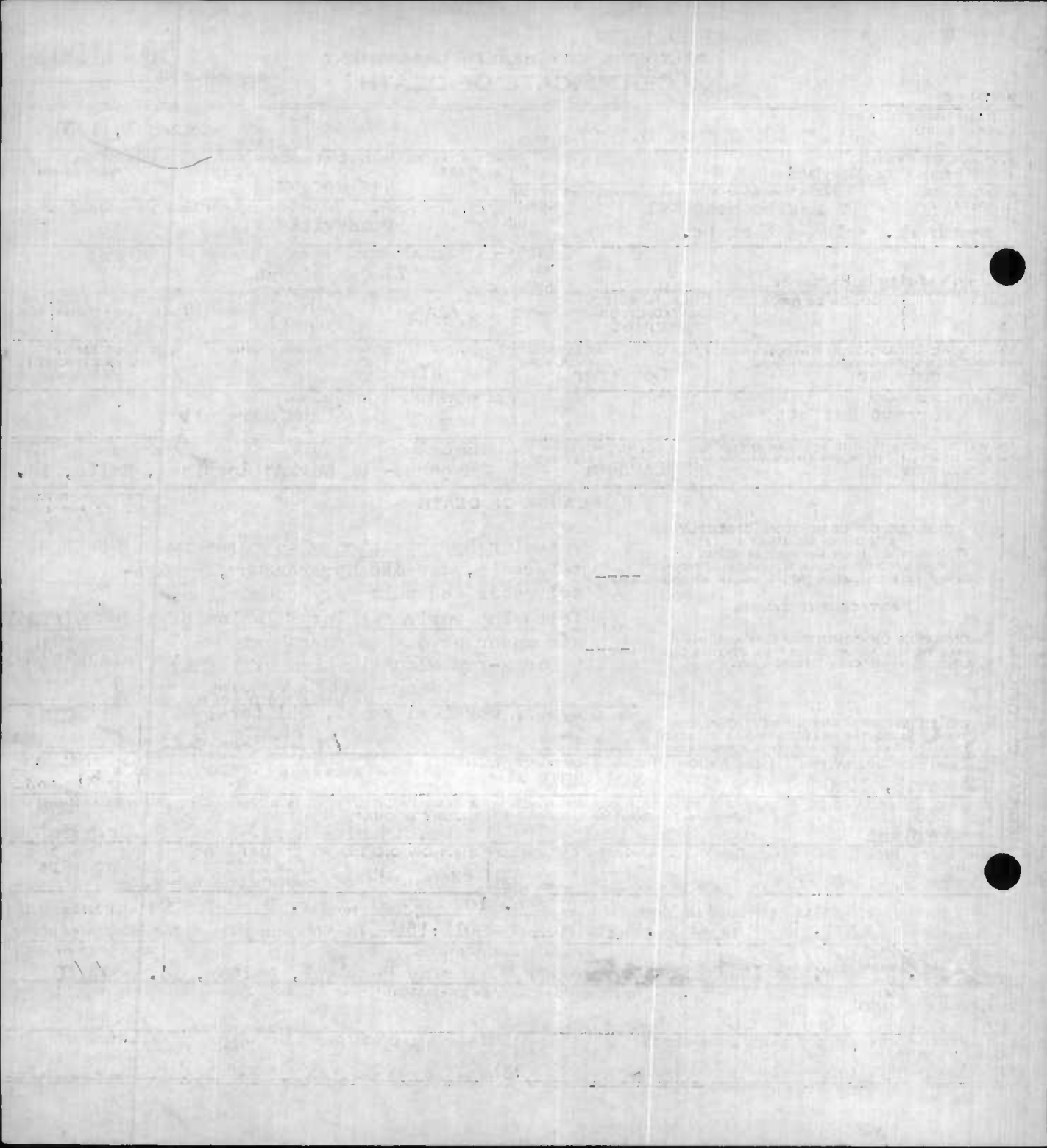
SECTION OF THE HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery		16. Signature of church	
17. Signature of family		18. Signature of neighbors		19. Signature of community		20. Signature of state	
21. Signature of federal government		22. Signature of international community		23. Signature of world		24. Signature of universe	
25. Signature of God		26. Signature of angels		27. Signature of saints		28. Signature of the Holy Spirit	
29. Signature of the Virgin Mary		30. Signature of the Holy Family		31. Signature of the Church		32. Signature of the Pope	
33. Signature of the Pope's representative		34. Signature of the Pope's representative		35. Signature of the Pope's representative		36. Signature of the Pope's representative	
37. Signature of the Pope's representative		38. Signature of the Pope's representative		39. Signature of the Pope's representative		40. Signature of the Pope's representative	
41. Signature of the Pope's representative		42. Signature of the Pope's representative		43. Signature of the Pope's representative		44. Signature of the Pope's representative	
45. Signature of the Pope's representative		46. Signature of the Pope's representative		47. Signature of the Pope's representative		48. Signature of the Pope's representative	
49. Signature of the Pope's representative		50. Signature of the Pope's representative		51. Signature of the Pope's representative		52. Signature of the Pope's representative	
53. Signature of the Pope's representative		54. Signature of the Pope's representative		55. Signature of the Pope's representative		56. Signature of the Pope's representative	
57. Signature of the Pope's representative		58. Signature of the Pope's representative		59. Signature of the Pope's representative		60. Signature of the Pope's representative	
61. Signature of the Pope's representative		62. Signature of the Pope's representative		63. Signature of the Pope's representative		64. Signature of the Pope's representative	
65. Signature of the Pope's representative		66. Signature of the Pope's representative		67. Signature of the Pope's representative		68. Signature of the Pope's representative	
69. Signature of the Pope's representative		70. Signature of the Pope's representative		71. Signature of the Pope's representative		72. Signature of the Pope's representative	
73. Signature of the Pope's representative		74. Signature of the Pope's representative		75. Signature of the Pope's representative		76. Signature of the Pope's representative	
77. Signature of the Pope's representative		78. Signature of the Pope's representative		79. Signature of the Pope's representative		80. Signature of the Pope's representative	
81. Signature of the Pope's representative		82. Signature of the Pope's representative		83. Signature of the Pope's representative		84. Signature of the Pope's representative	
85. Signature of the Pope's representative		86. Signature of the Pope's representative		87. Signature of the Pope's representative		88. Signature of the Pope's representative	
89. Signature of the Pope's representative		90. Signature of the Pope's representative		91. Signature of the Pope's representative		92. Signature of the Pope's representative	
93. Signature of the Pope's representative		94. Signature of the Pope's representative		95. Signature of the Pope's representative		96. Signature of the Pope's representative	
97. Signature of the Pope's representative		98. Signature of the Pope's representative		99. Signature of the Pope's representative		100. Signature of the Pope's representative	

1. NAME OF DECEASED (Type or Print) JAMES CULBERTSON MOFFETT			2. DATE OF DEATH March 2, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New Jersey B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION US Marine Hospital Wyman Pk. Drive & 31st St.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pennsville		
Length of stay in Baltimore ? Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 73 Oak Street		
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8/8/84	9. AGE (In years last birthday) 65	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) NY	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Garrett Moffett		
14. MOTHER'S MAIDEN NAME Mary Elizabeth Marshall			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.		

18. 442.X E954X	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Vascular hypertension with coronary sclerosis, cardiac hypertrophy, nephrosclerosis and pulmonary congestion.	UNKNOWN
ANTECEDENT CAUSES		(B) following perirenal insufflation of air under novocaine anesthesia (for x-ray visualization of right kidney)	IMMEDIATELY
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) Cysts, cortical renal, bilateral	UNKNOWN
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY RS Fisher	

19A. DATE OF OPERATION March 2, 1950	19B. MAJOR FINDINGS OF OPERATION SEE ABOVE	CHIEF OR ASST. MEDICAL EXAMINER RS Fisher	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hospital	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) U.S. Marine Hosp.-Wyman Pk. Dr. & 31st St	21F. HOW DID INJURY OCCUR? of kidney region flation of air for x-ray
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY March 2, 1950 11:15 A.m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	Ingestion of novocaine anes. and insuff-	
22. I hereby certify that I attended the deceased from Feb. 16, 1950, to Mar. 2, 1950, that I last saw the deceased alive on Mar. 2, 1950, and that death occurred at 11:15 A.m., from the causes and on the date stated above.			
23A. SIGNATURE John L. Wilson, Medical Director	23B. ADDRESS US Marine Hospital, Balto. Md.	23C. DATE SIGNED 3/3/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 3-7-50	24C. NAME OF CEMETERY OR CREMATORY Cathedral	24D. LOCATION (City, town, or county) (State) Wilmington, Del
DATE RECEIVED BY LOCAL REGISTRAR MAR 4 - 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR [Signature]	ADDRESS 2503 Edmondson



416

50 1905

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1905

Registered No.

1. NAME OF DECEASED
(Type or Print)

Mack D. Coulbourn

2. DATE
OF
DEATH

Mar. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

8-03

D. STREET ADDRESS (If rural, give location)

1205 N. DECKER AVE.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

1205 N. DECKER ST.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

W

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

JULY 1, 1877

9. AGE (in years
last birthday)

72

If Under 1 Year
Months: Days Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR
INDUSTRY

MAINTENANCE

11. BIRTHPLACE (State or foreign country)

DORCHESTER CO.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

JAMES A COULBOURN

14. MOTHER'S MAIDEN NAME

ALICE COLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

218-01-3034

17. INFORMANT

ADDRESS

Laura V. Coulbourn 1307 N. Calvert St.

18. 162X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Bronchogenic Carcinoma

8 months

ANTECEDENT CAUSES

(B)

DUE TO

None

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

None

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

None

21C. WHERE DID
INJURY OCCUR?

None.

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

None

21E. INJURY OCCURRED

WHILE AT WORK ☐ WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

None

22. I hereby certify that I attended the deceased from Nov. 1, 1949, to Mar. 4, 1950, that I last saw the deceased alive on Feb. 25, 1950, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

J. Carl Meyer M.D.

23B. ADDRESS

M. D.

1404 E. Cold Spring Lane -

Mar. 4, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

WASHINGTON CEM.

24D. LOCATION (City, town, or county) (State)

HURLOCK, MD.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

[Signature]

25. FUNERAL DIRECTOR

ADDRESS

J. FRAMPTON FEDERALSBURG, MD.

SAFETY NO. 2

ATJWA

1-1-1

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1906

Registered No. _____

563
50 1906

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) LENHARDT, EDITH. A.		2. DATE OF DEATH 2 MARCH 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland FRANKLIN Sq. Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY BALTIMORE	
B. FULL NAME OF (If not in hospital or institution) give street address or HOSPITAL OR FRANKLIN SQUARE HOSPITAL location) INSTITUTION FAYETTE + CALHOUN STS. BALTI, MD.		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTIMORE. 27-05	
5. Length of stay in Baltimore LIFE.		D. STREET ADDRESS (If rural, give location) 6207 HAREFORD RD.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED.	8. DATE OF BIRTH APRIL 14 1903.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE.		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME JOSEPH BISHOP		14. MOTHER'S MAIDEN NAME MARY SENFT.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT HUSBAND. HENRY LENHARDT.		ADDRESS SAME	

<p>18. 446 X</p> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p align="center">ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) Uremia</p> <p>QUE TO</p> <p>(B) Nephrosclerosis</p> <p>QUE TO</p> <p>(C) Malignant ess. Hypertension</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>1 mo.</p> <p>not known</p> <p>not known.</p>
--	--	--

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from **8 FEB.**, 19**50**, to **2 MARCH**, 19**50** that I last saw the deceased alive on **2 MARCH**, 19**50**, and that death occurred at **5.20 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE John W. Demand		23B. ADDRESS M. O. Franklin Square Hosp. Balti. Md		23C. DATE SIGNED 2 March 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/6/50	24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	24D. LOCATION (City, town, or county) (State) Belair Rd		
DATE RECEIVED BY LOCAL REGISTRAR MAR 4 - 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR Clayton P. Hoffman		ADDRESS 1639 Broadway	

MEDICAL CERTIFICATION

correct age is especially important. In physicians, please write the cause of death clearly and legibly.

STATE OF NEW YORK
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Place of Birth		6. Usual Residence		7. Cause of Death		8. Manner of Death	
9. Name of Physician		10. Name of Undertaker		11. Name of Burial Place		12. Name of Funeral Home	
13. Name of Coroner		14. Name of Medical Examiner		15. Name of Registrar		16. Name of Clerk	
17. Name of Witness		18. Name of Witness		19. Name of Witness		20. Name of Witness	
21. Name of Witness		22. Name of Witness		23. Name of Witness		24. Name of Witness	
25. Name of Witness		26. Name of Witness		27. Name of Witness		28. Name of Witness	
29. Name of Witness		30. Name of Witness		31. Name of Witness		32. Name of Witness	
33. Name of Witness		34. Name of Witness		35. Name of Witness		36. Name of Witness	
37. Name of Witness		38. Name of Witness		39. Name of Witness		40. Name of Witness	
41. Name of Witness		42. Name of Witness		43. Name of Witness		44. Name of Witness	
45. Name of Witness		46. Name of Witness		47. Name of Witness		48. Name of Witness	
49. Name of Witness		50. Name of Witness		51. Name of Witness		52. Name of Witness	
53. Name of Witness		54. Name of Witness		55. Name of Witness		56. Name of Witness	
57. Name of Witness		58. Name of Witness		59. Name of Witness		60. Name of Witness	
61. Name of Witness		62. Name of Witness		63. Name of Witness		64. Name of Witness	
65. Name of Witness		66. Name of Witness		67. Name of Witness		68. Name of Witness	
69. Name of Witness		70. Name of Witness		71. Name of Witness		72. Name of Witness	
73. Name of Witness		74. Name of Witness		75. Name of Witness		76. Name of Witness	
77. Name of Witness		78. Name of Witness		79. Name of Witness		80. Name of Witness	
81. Name of Witness		82. Name of Witness		83. Name of Witness		84. Name of Witness	
85. Name of Witness		86. Name of Witness		87. Name of Witness		88. Name of Witness	
89. Name of Witness		90. Name of Witness		91. Name of Witness		92. Name of Witness	
93. Name of Witness		94. Name of Witness		95. Name of Witness		96. Name of Witness	
97. Name of Witness		98. Name of Witness		99. Name of Witness		100. Name of Witness	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1907
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DOROTHY

TEMPLETON

2. DATE OF DEATH February 27, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

519 Hoffman Street, W.

Length of stay in Baltimore

36 Yrs.
Mos.
Days

5. SEX
Female

6. COLOR OR RACE
Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

Oct-?-1913

9. AGE (In years last birthday)

36

10 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Belair Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Sam Daughtery

14. MOTHER'S MAIDEN NAME

Mary Alice ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS
Sidney Templeton - Hoffman St

18. 142-1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of parotid gland

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED
2-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 4 - 1950

A. Holstead - 918 - Hill Ave.

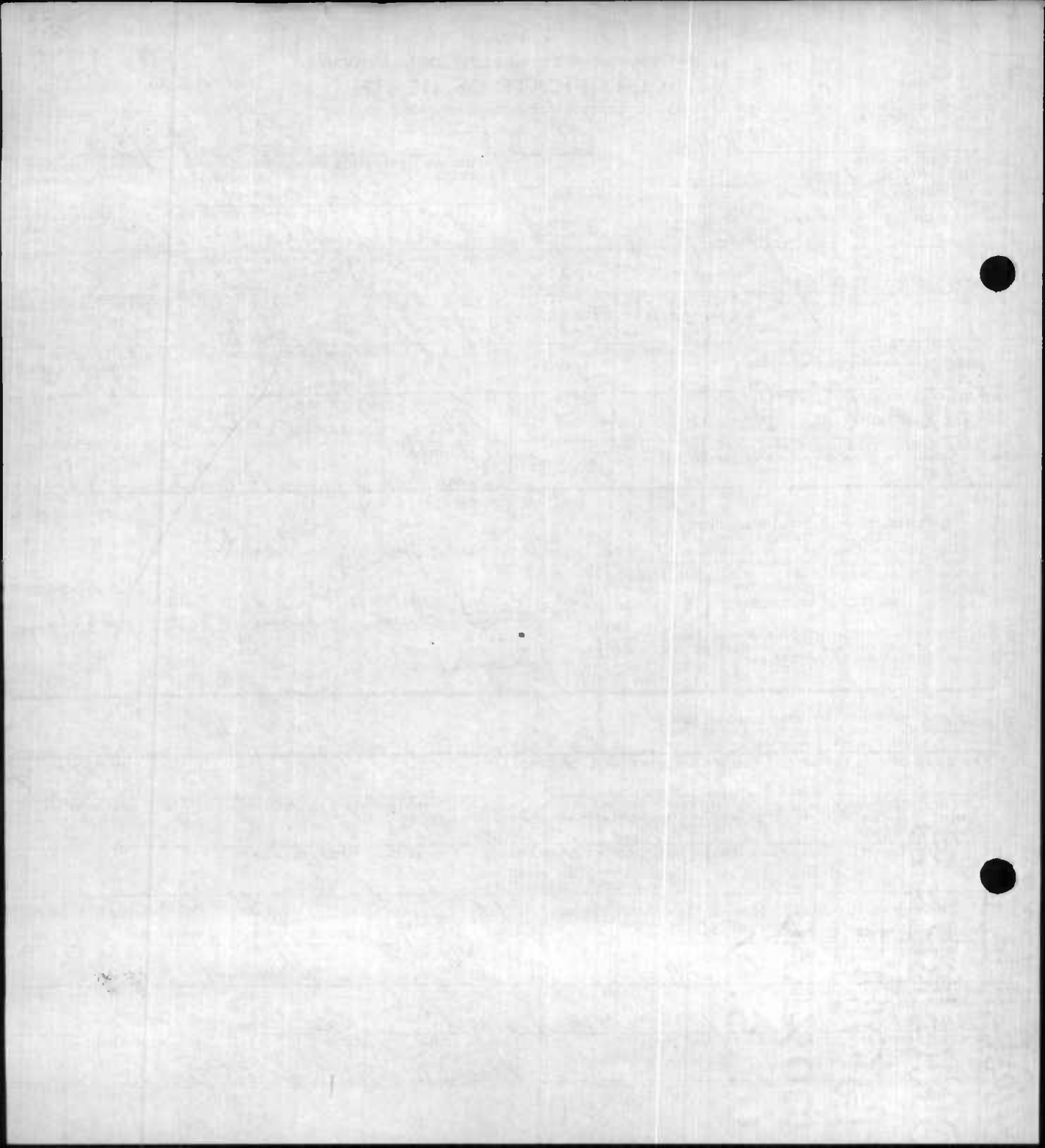
DECLARATION OF DEATH

230
50 1908BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 1908
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Anne West</i>			2. DATE OF DEATH <i>3/3/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>St Agnes Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Catonsville - 28</i>		
Length of stay in Baltimore _____ Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <i>308 Ingleside Ave.</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12/22/1883</i>		9. AGE (In years last birth day) <i>66</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Alfred E. Bresee (dec'd)</i>			14. MOTHER'S MARDEN NAME <i>Mary Passano (dec'd)</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <i>Anne West Jenny Montchamni, Del.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		ADDRESS	

18. <i>572.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Generalized peritonitis</i> DUE TO (A) _____		INTERVAL BETWEEN ONSET AND DEATH <i>approx. 25 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Ruptured diverticulitis, sigmoid</i> DUE TO (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>3/3/50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2/7</i> , 19 <i>50</i> , to <i>3/3</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3/3</i> , 19 <i>50</i> , and that death occurred at <i>10:40</i> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Herbert J. Leichas</i> M. D.		23B. ADDRESS <i>St. Agnes Hospital</i>		23C. DATE SIGNED <i>3/3/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Mar 6/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Green Mount</i>	
24D. LOCATION (City, town, or county) <i>Baltimore Md</i>		24E. (State)		25. FUNERAL DIRECTOR <i>Henry W. Jenkins & Sons Co.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 4 - 1950</i>		REGISTRAR'S SIGNATURE <i>William J. Williams</i>		ADDRESS	



625
50 1909GREEN
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1909
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Lena Dreacen

2. DATE
OF
DEATH

3-3-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

The Union Memorial Hospital

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

9-04

D. STREET ADDRESS (If rural, give location)

2715 Greenmount Ave

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

July 31, 1887

9. AGE (In years
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Maid

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS Same

Mrs Margaret Mc Dermott

18. 443.X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

18 hr

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardiovascular
Disease

Unknown

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐
WORKNOT WHILE ☐
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 2, 1950, to Mar 3, 1950, that I last saw the
deceased alive on Mar 3, 1950, and that death occurred at 2:55 Am., from the causes and on the date stated above.

23A. SIGNATURE

Richard K. Beach

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

Prospect Hill

24D. LOCATION (City, town, or county)

Towson, Balto. Co.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

WIEDEFFELD & SON

ADDRESS

MAR 4 - 1950

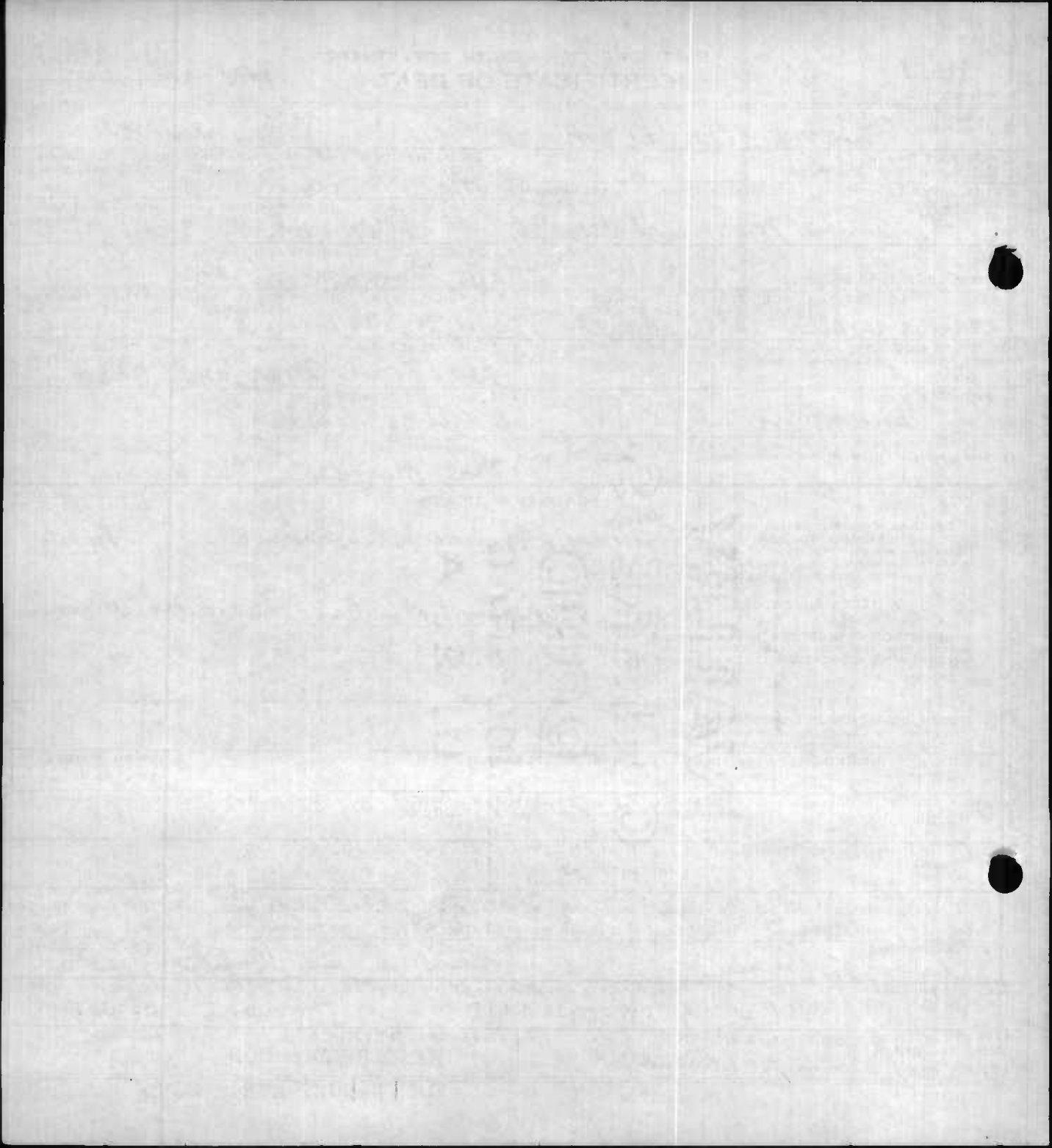
VS 150

GREENMOUNT AVE & 22ND

52086

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.



-616

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1910

BIRTH NO. 1910

1. NAME OF DECEASED (Type or Print) WILLIAM E. CRAWFORD		2. DATE OF DEATH 3-2-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 659 PORTLAND ST.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. LENGTH OF STAY IN BALTIMORE 15 Yrs. Mos. Days		E. STREET ADDRESS (If rural, give location) 659 Portland St.	
5. SEX M	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-13-1899
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Polisher		10B. KIND OF BUSINESS OR INDUSTRY Carlyle Glass Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM CRAWFORD		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. 212-05-8142	
17. INFORMANT MARY M CRAWFORD		ADDRESS 659 PORTLAND ST	
18. 162 X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Squamous Cell Carcinoma of Trachea DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hernia right inguinal OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hernia right inguinal			INTERVAL BETWEEN ONSET AND DEATH 6 mos.
19A. DATE OF OPERATION Jan 1950		19B. MAJOR FINDINGS OF OPERATION Squamous Cell Carcinoma of trachea	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept 12, 1949 to 3-2, 1950 , that I last saw the deceased alive on 3-2, 1950 , and that death occurred at 1:30 P. M. , from the causes and on the date stated above.			
23A. SIGNATURE John P. Urlick, Jr.		23B. ADDRESS 1222 Wash Blvd	
23C. DATE SIGNED 3-4-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 3-6-50	24C. NAME OF CEMETERY OR CREMATORY West Cathedral	24D. LOCATION (City, town, or county) (State) Old Druid Rd Md
DATE RECEIVED BY LOCAL REGISTRAR MAR 4 - 1950		REGISTRAR'S SIGNATURE Thos. W. Jachauskas	
25. FUNERAL DIRECTOR Thos. W. Jachauskas		ADDRESS 703 McKenny St	

STATE OF TEXAS
COUNTY OF DALLAS

1900

Blank lined area for text entry.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1911
Registered No. _____

236
1911
BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) NANCY		2. DATE OF DEATH March 3, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township.) Baltimore	
D. STREET ADDRESS (If rural, give location) 1711 Windemere Avenue		E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH May 18, 1932
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 17
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry R. Rector		14. MOTHER'S MAIDEN NAME Mary Blair	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Harry Rector		ADDRESS 1711 Windemere Ave.	

18. E 819.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Crushing injuries of head DUE TO _____ (B) _____ DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH

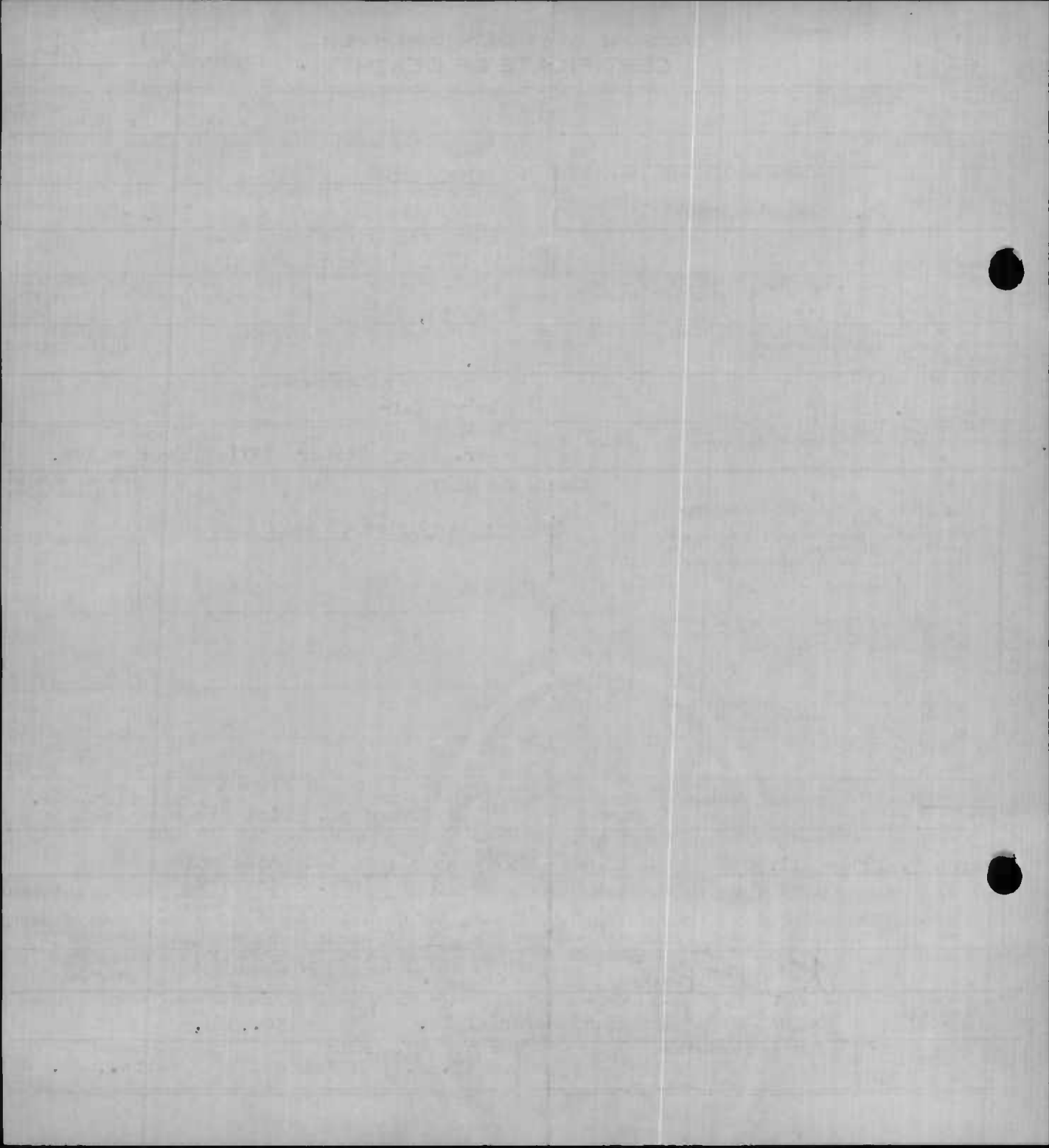
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fullerton, Md. Hazelwood nr. Point Pleasant Road, 5200	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY March 3, 1950 11:20 P m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Auto into telephone pole	
22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE RS Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 3-4-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/6/50		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.	
24D. LOCATION (City, town, or county) (State) Balto., Md.					
DATE RECEIVED BY LOCAL REGISTRAR MAR 4 - 1950		REGISTRAR'S SIGNATURE Wm. J. Tickner & Sons		25. FUNERAL DIRECTOR Wm. J. TICKNER & SONS	
				ADDRESS Balto., Md.	

VS 151
N-803.2

170c

correct age is important in reporting. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION



R-360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 1912

BIRTH NO.

50 1912

1. NAME OF DECEASED
(Type or Print)

John P. Rader

2. DATE
OF
DEATH

3/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

Balto.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

West Balto. Gen. Hosp

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Cub Hill

D. STREET ADDRESS (If rural, give location)

Cub Hill Road

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov. 1st, 1888

9. AGE (In years
last birthday)

61

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

dairy farmer

10B. KIND OF BUSINESS OR INDUSTRY

dairy

11. BIRTHPLACE (State or foreign country)

Balto. Co., Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Rader

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. J. P. Rader, Cub Hill Rd., Towson, Md.

18.

162X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinoma of the lung with
granulosa metastases

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from 2/21, 1950, to 2/2, 1950, that I last saw the deceased alive on 2/2, 1950, and that death occurred at 10:27 P. m. from the causes and on the date stated above.

23A. SIGNATURE

Katharine V. Krump

M. D.

23B. ADDRESS

West Balto. Gen. Hosp

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

burial

24B. DATE

Mar. 5, 1950

24C. NAME OF CEMETERY OR CREMATORY

St. Johns Luth. Cemetery

24D. LOCATION (City, town, or county)

Parkville, Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Lansbury Funeral Home 7401 Belair Rd.

MAR 5 - 1950

000VV

47D

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

R-263

50 1913

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1913

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)2. DATE
OF
DEATH

3-3-50

3. PLACE OF DEATH

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

Balto.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Overlea

D. STREET ADDRESS (If rural, give location)

6919 Belair Road

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Fred A. Reichert, 6919 Belair Rd.

18. 470.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

3-3-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

burial

Mar. 6, 1950

Baltimore Cemetery

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Lapinsky Funeral Home 7401 Belair Rd.

49621

94a ✓

CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.

R-240

50 1914

50 1914

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES RUSSELL

2. DATE
OF
DEATH

March 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

43 S. STRICKER ST.

Length of stay in Baltimore

40 YRS.

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

March 11, 1880

9. AGE (In years
last birthday)

69

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

STEAM FITTER

10B. KIND OF BUSINESS OR
INDUSTRY

Boilers

11. BIRTHPLACE (State or foreign country)

NEBRASKA

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No. None

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Wm. C. Russell 1505 McHenry St.

18. 352 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Broncho Pneumonia

DUE TO

1 Week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Hemiplegia - right side

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Jan. 1, 1944 to March 3, 1950 that I last saw the deceased alive on March 3, 1950 and that death occurred at 11:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Albert Kermisch

M. D.

23B. ADDRESS

1934 Wilkens Ave.

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

March 6, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt. Olivet

24D. LOCATION (City, town, or county)

BALTIMORE MARYLAND.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 5 - 1950

Geo. L. Schwab 2101 Frederick Ave.

VS 150

34830 1016

83D

AVE.

Correct age is especially important. In patients, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF MARITIME SERVICE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

H-362

50 1915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1915

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John William Hedrick

2. DATE
OF
DEATH

March 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

334 S. Pulaski St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 20-05

D. STREET ADDRESS (If rural, give location)

334 S. Pulaski St.

Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Aug. 11, 1883

9. AGE (In years
last birthday)

66

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Body Repairman

10B. KIND OF BUSINESS OR
INDUSTRY

Automobiles

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

HENRY HEDRICK

14. MOTHER'S MAIDEN NAME

LENA KLINER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

NONE

16. SOCIAL
SECURITY NO.

217-18-8149

17. INFORMANT

ADDRESS

EMMA A. HEDRICK 334 S. Pulaski St.

18. 443 X 1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Hypertensive cardiac
vascular disease

1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/19/49 to 3/3/50, that I last saw the
deceased alive on 3/3/50, and that death occurred at 2:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Benjamin Miller MD

M. D.

23B. ADDRESS

2030 Wilkes Ave 3/4/50

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

MAR. 7, 1950

ST. PAUL'S CEMETERY

BALTIMORE MD

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 5 - 1950

Geo. L. Schwab 2101 Frederick Ave.

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,
January 10, 1912.

REPORT
OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1911.

ALBANY:

J. B. LEECH, PRINTERS.

1912.

THE STATE OF NEW YORK

OFFICE OF THE ATTORNEY GENERAL

IN SENATE,

January 10, 1912.

REPORT

OF THE

COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1911.

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

ANNA SILVERMAN

2. DATE
OF
DEATH

3 MARCH 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

O. STREET ADDRESS (If rural, give location)

3818 Boarman Ave

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

1887

9. AGE (In years last birthday)

63

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10B. KIND OF BUSINESS OR INDUSTRY

OWN Home

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Louis Cohen

14. MOTHER'S MAIDEN NAME

Rachel Levinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS **3818 Orrin Revillon Silverman Boarman Ave**

18. **443 X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

cerebro-vascular accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

hypertensive cardio-vasc. disease

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **2/28**, 19**50** to **3/3**, 19**50**, that I last saw the deceased alive on **3/3**, 19**50**, and that death occurred at **12:17** pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

William Kraker

M. D.

Sinai Hospital

3/3/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

March 5, 1950

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Friendship Cemetery

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Therese J. Williams

25. FUNERAL DIRECTOR

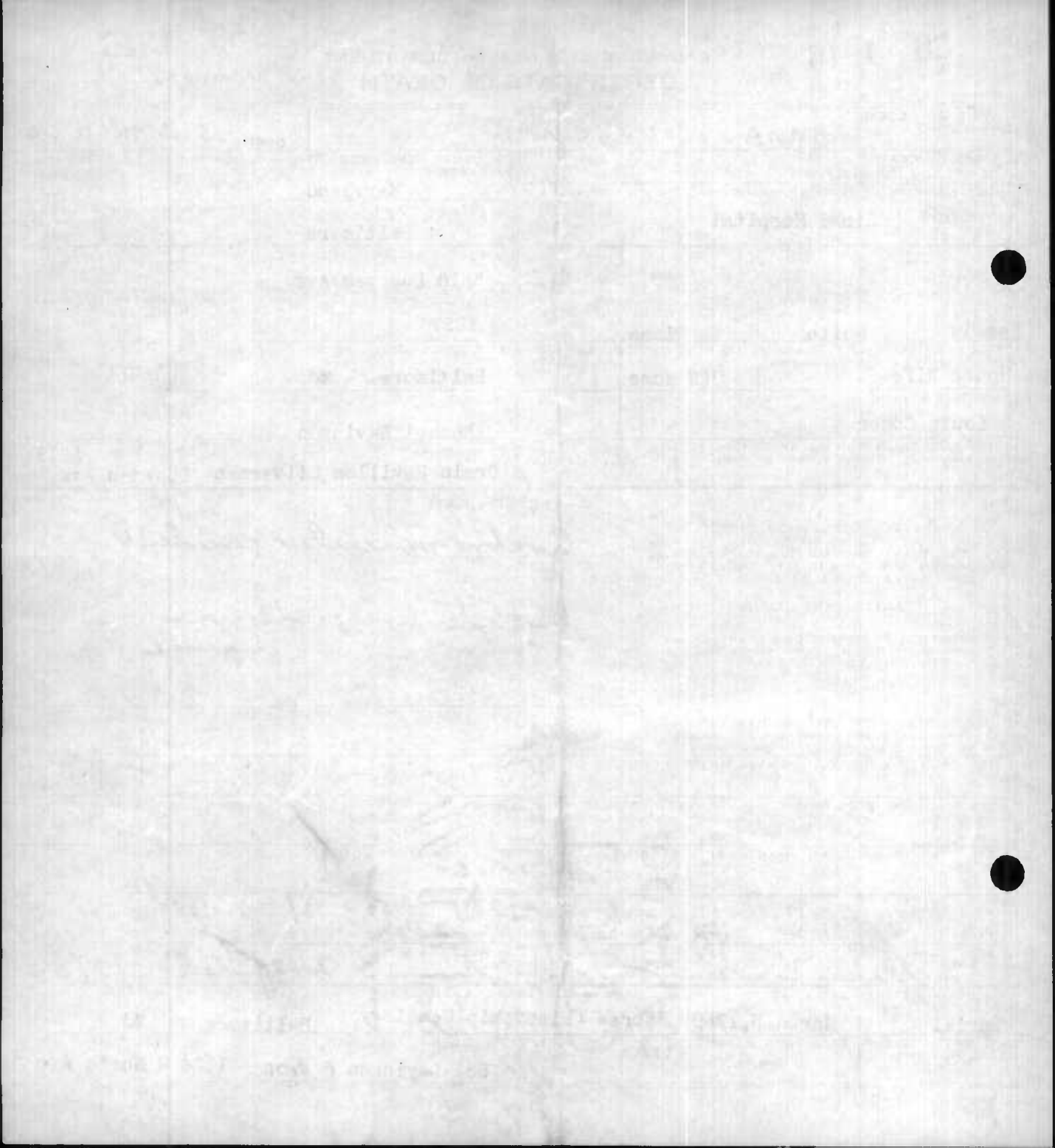
Sol Levinson & Bros

ADDRESS

1126 W North Ave

MAR 5 - 1950

937



M-460

50 1917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1917

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

James L. Miller Jr.

2. DATE
OF
DEATH

MAR - 1 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 12-03

D. STREET ADDRESS (If rural, give location)

423 Whitridge Ave

Length of stay in Baltimore

Divorced

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

W. Va.

13. FATHER'S NAME

James L. Miller Sr.

14. MOTHER'S MAIDEN NAME

Laura Ann Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT ADDRESS

yes no

218-01-0399

JOHNS HOPKINS HOSPITAL

18. 150 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) ? Cerebral metastases
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Carcinoma of Esophagus 8 mos
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Renal Failure

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg, etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 2-1-1950, to 3-1-1950, that I last saw the
deceased alive on 3-1-1950, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Paul C. Schmidt

M. D.

JOHNS HOPKINS HOSPITAL

3-3-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3/7/50

Baltimore National

Frederick Ave Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 5 - 1950

Meredith J. Bright, 6009 Harford Rd

46a

Correct age is especially important. In parentheses, please write the cause of death clearly and legibly.

AD136283

S-552 50 1918

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX 50 1918
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Harold Joseph Simmons

2. DATE
OF
DEATH

3-34 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE Baltimore City Hospitals
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE Maryland B. COUNTY BaltimoreC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Rural) Dundalk

D. STREET ADDRESS (If rural, give location)

2949 Yorkway

Length of stay in Baltimore

2yrs

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH

June 21-1916

9. AGE (In years;
last birthday)

33

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of work life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

W.Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Wheeler Simmons

14. MOTHER'S MAIDEN NAME

Belle Hays

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes World War II

16. SOCIAL
SECURITY NO.17. INFORMANT Baltimore City Hospitals
Records: 4940 Eastern Ave.

18. 4/20/1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) CERTIFICATION APPROVED BY
E. H. Rye M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-3-1950, to 3-3-1950, that I last saw the
deceased alive on 3-3-1950, and that death occurred at 7.45 Pm., from the causes and on the date stated above.

23A. SIGNATURE

J. D. Rogers M. D.

23B. ADDRESS

Baltimore City Hospitals

23C. DATE SIGNED

3-4-1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 5 - 1950

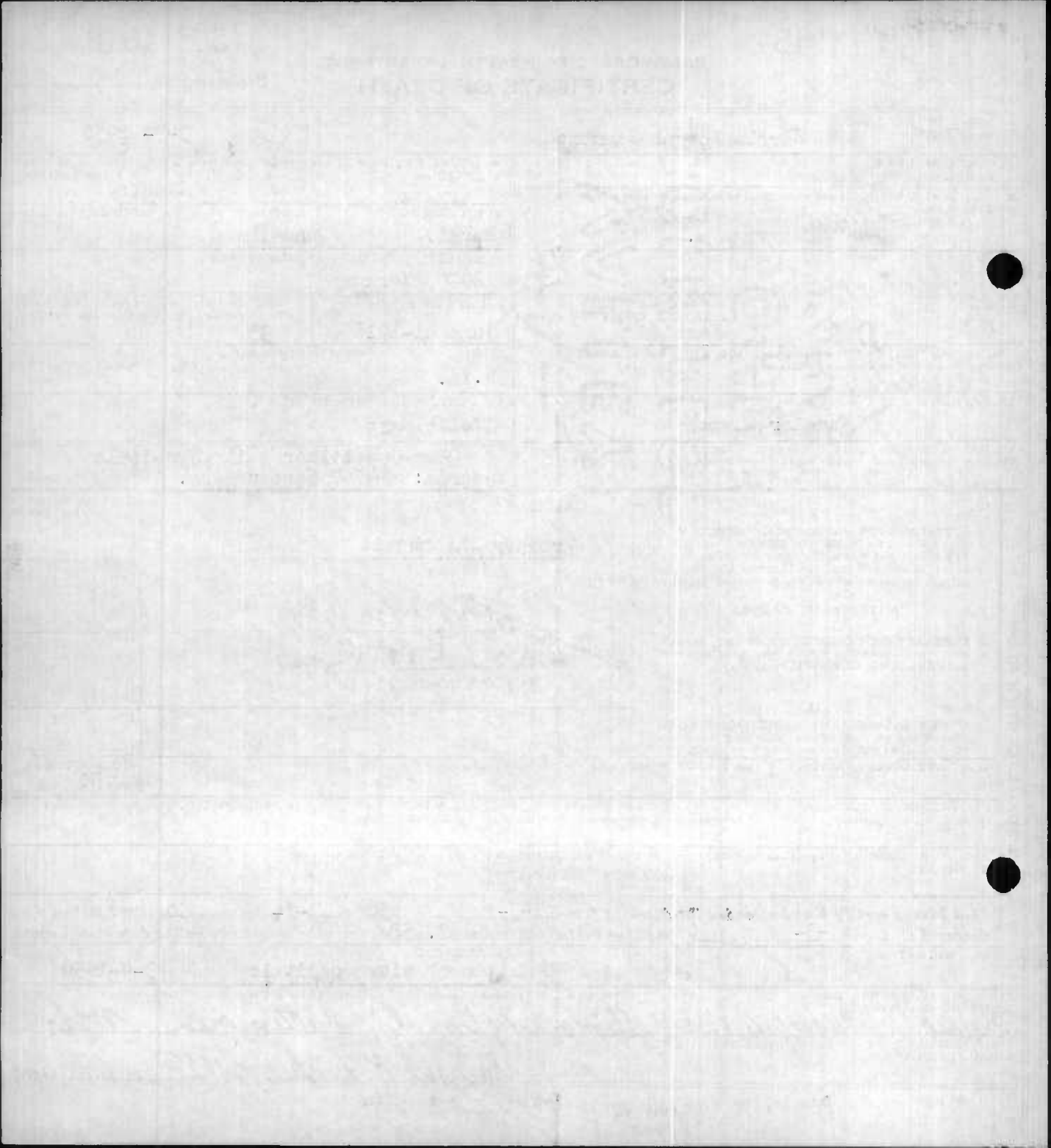
To be approved by the Medical Examiner

308V9

94a

MEDICAL CERTIFICATION

correct age is especially important. If physicians please write full names of Dean, Clergy, and Registry.



M-635
50 1919BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1919
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Augusta Martin</i>			2. DATE OF DEATH <i>MARCH 3 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore Md</i>			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>BALTIMORE</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore Gen. Hospital</i>			C. CITY OR TOWN <i>DUNDALK</i>		
Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <i>919 OAKLEIGH BEACH AVE.</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>Nov. 2 1884</i>		9. AGE (In years last birthday) <i>65</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>COOK</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i>	11. BIRTHPLACE (State or foreign country) <i>VIENNA, AUSTRIA</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>MYRON MARTIN 2613 LIBERTY RD</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Generalized Carcinomatosis</i> DUE TO <i>probably liver</i> INTERVAL BETWEEN ONSET AND DEATH <i>over</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>3 - 3 - 50</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>2-28-50</i> , 1950, to <i>3-3</i> , 1950 that I last saw the deceased alive on <i>3-3-50</i> , and that death occurred at <i>2:10 AM</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <i>S. BALTO. GEN HOSP.</i>		23C. DATE SIGNED <i>3/3/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>MARCH 6 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MORELAND MEM. PK.</i>	
24D. LOCATION (City, town, or county) (State) <i>BALTO. Co, M.D.</i>		24E. FUNERAL DIRECTOR <i>ROLAND L. FISHER DUNDALK, MD</i>		24F. ADDRESS <i>21129 Dundalk Ave</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		52086 9 2 1 46 F	

MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Letter in document file 50-1919 4/5/50.

K-500
50 1920BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1920
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>MR. SYLVAN KAHN</u>		2. DATE OF DEATH <u>3/13/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Fuller St Maryland</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS Hosp.</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTIMORE 20-01</u>	
D. STREET ADDRESS (If rural, give location) <u>2420 Fuller St</u>		E. Length of stay in Baltimore <u>53 yrs</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12/12/96</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosted Bedding</u>		9. AGE (In years last birthday) <u>53</u>	
10B. KIND OF BUSINESS OR INDUSTRY <u>Paint Sprayer</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>	
13. FATHER'S NAME <u>Ignace Kahn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Augusta Meyer</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ignace Kahn 2420 Fuller St</u>	
		ADDRESS <u>City</u>	

18. 159X CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)
Carcinoma tris. abd.INTERVAL BETWEEN ONSET AND DEATH
over

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
anaplastic adenocarcinoma

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus

19A. DATE OF OPERATION <u>2/9/50</u>		19B. MAJOR FINDINGS OF OPERATION <u>Carcinoma tris.</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>no</u>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office hldg., etc.) <u>none</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 24 1950 to March 3 1950 that I last saw the deceased alive on March 3, 1950, and that death occurred at 8:30 Am., from the causes and on the date stated above.

23A. SIGNATURE <u>D. J. Shohler</u>		23B. ADDRESS <u>Bon Secours Hosp.</u>		23C. DATE SIGNED <u>3/13/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>March 5, 1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Ches. Shalom O'Donnell St Md</u>	
24D. LOCATION (City, town, or county) (State) <u>1802 East</u>		25. FUNERAL DIRECTOR <u>Daniel Sordheim Son</u>		ADDRESS <u>1802 East</u>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE			

MAR 5 - 1950

4581V

55E

portant. Physicians, please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

First organ or part affected could not be determined at operation.
Letter in document file 50-1920 4/5/50.

B-634

50 1921

50 1921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles Francis Bradley

2. DATE
OF
DEATH

March - 3 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2901 Annapolis Rd

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore 25-42

D. STREET ADDRESS (If rural, give location)

2901 Annapolis Road

c. Length of stay in Baltimore

life

67

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

1883

9. AGE (in years
last birthday)

67

10 Under 1 Year
Months Days11 Under 24 Hours
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CRANE DRIVER

10B. KIND OF BUSINESS OR INDUSTRY

retired

11. BIRTHPLACE (State or foreign country)

not known, probably Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

not known

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

marinel corps.

16. SOCIAL
SECURITY NO.

217-12-3227

17. INFORMANT

Mr. Allen Barnes 2901 Annapolis Rd

ADDRESS

18. 442 X I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Cerebral hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH

one hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

Cardio-vascular-renal disease

DUE TO

Hypertension

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan - 30, 1950, to March 3, 1950, that I last saw the deceased alive on March - 3 - 1950, and that death occurred at 5 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Walter J. J. J. J.

23B. ADDRESS

M. D.

2108 Hollister Rd

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMATION,
TOMB REMOVAL (Specify)

24B. DATE

3-6-50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county)

Pitkin - Hgman

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Edward J. J. J.

MAR 5 1950

VS 150

358V9

121a

MEDICAL CERTIFICATION

Mulder - 8/22/20
Franklin
Chas. Franklin

1258
3021
1508

J-100

50 1922

50 1922

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

WALTER H. JUBB

2. DATE
OF
DEATH

3/3/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

South BALTO. GEN

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

24-01

D. STREET ADDRESS (If rural, give location)

1345 ANDRE ST.

Length of stay in Baltimore

36

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

4-23-1913

9. AGE (In years
last birthday)

36

11 Under 1 Year
Months: Days12 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

STEVEDORE

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF
WHAT COUNTRY?

USA-

13. FATHER'S NAME

John

Jubb

14. MOTHER'S MAIDEN NAME

CARRIE

WARR

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

NO

16. SOCIAL
SECURITY NO.

212-03-4934

17. INFORMANT

LOUISE Jubb

ADDRESS

1345 ANDRE ST.

18. 581.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *Portal cirrhosis*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C)
DUE TO

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from 2-11-1950, to 3-3-1950, that I last saw the
deceased alive on 3-3-1950, and that death occurred at 2 A. M., from the causes and on the date stated above.

23A. SIGNATURE

HARRY D. JEFFERSON

M. D.

23B. ADDRESS

1213 Light St.

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3-3-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross

24D. LOCATION (City, town, or county)

G. G. Co.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Charles F. Dill

1501 E. Foster

MAR 5 1950

VS 150

90657

12412

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

RECEIVED BY THE DIRECTOR
GENERAL INVESTIGATIVE DIVISION

3/2/58

WALTER H. COBB

Walter H. Cobb

5-11-58
5-11-58
5-11-58

Walter H. Cobb

K-613

50 1923

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1923
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Matthew John Kraft

2. DATE
OF
DEATH

3/3/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4361 Shamrock Avenue

C. Length of stay in Baltimore

65

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Plater

10B. KIND OF BUSINESS OR
INDUSTRYGold & Silver
Plating

13. FATHER'S NAME

Michael Kraft

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived, If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4361 Shamrock Avenue

8. DATE OF BIRTH

4/19/85

9. AGE (in years
last birthday)

64

65

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Jennie Greer

17. INFORMANT

ADDRESS

Mrs. M. J. Kraft 4361 Shamrock Av

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO
(C)Coronary Thrombosis
Arteriosclerotic Cardio-
vascular disease.II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from May 1947 to Mar 3, 1950 that I last saw the
deceased alive on Mar 1, 1950, and that death occurred at 10:30 AM from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/6/50

New Cathedral

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

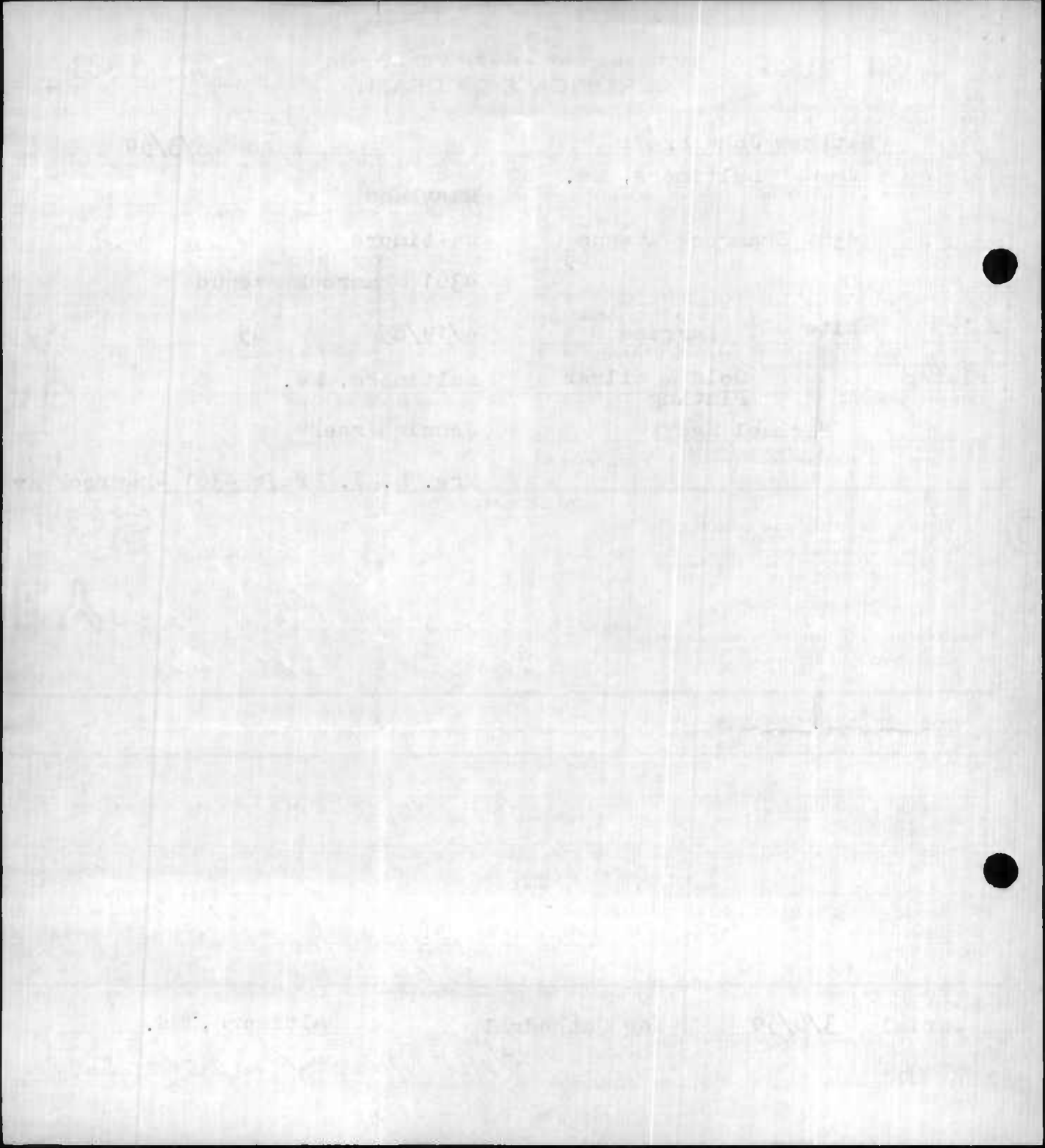
MAR 5 - 1950

VS 150

49632 1 2 2 5

937

MEDICAL CERTIFICATION



D-252

50 1924

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1924

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary Margaret Isensee

2. DATE
OF
DEATH

March 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

2653 W. Lafayette Ave.

Yrs.
Mos.
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2653 W. Lafayette Ave.,

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Dec. 7, 1867

9. AGE (In years
last birthday)

82

If Under 1 Year
Months Days If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Andrew J. Rentz

14. MOTHER'S MAIDEN NAME

Mary J. Null

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mrs. Walter S. Webb 2653 W. Lafayette Ave.

18. 592X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

3-1-50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Chr Myocarditis

1940

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO

chr. Intestinal Definitis

1940

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 12, 1950, to Mar 3, 1950 that I last saw the
deceased alive on Mar 3, 1950, and that death occurred at 9:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3-6-50

Meadowridge Mem. Park

Elkridge,

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

G. Howard Strong 3207 W. North Ave.,

MAR 5 - 1950

131a

Dr Paul Brown
1863 W. Va. 16 Ave.

5-140
50 1925BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1925
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Nancy R. Schaefer

2. DATE
OF
DEATH

3/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2842 W. North Ave.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 2, 1905

9. AGE (In years last birthday)

44

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Practical Nurse

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Westernport, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

J. Grant Hayden

14. MOTHER'S MAIDEN NAME

Caroline Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. E8720

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Methol salicylate poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

chronic alcoholism

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

2842 W. North Avenue

15/6

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

March 4, 1950 ? a. m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Accidental ingestion of the methol salicylate

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER... ASSISTANT MEDICAL EXAMINER... MEDICAL INVESTIGATOR

23C. DATE SIGNED

5 Mar 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

Pharos Cem.

24D. LOCATION (City, town, or county) (State)

Westernport, Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 5 - 1950

Wm Jickner & sons

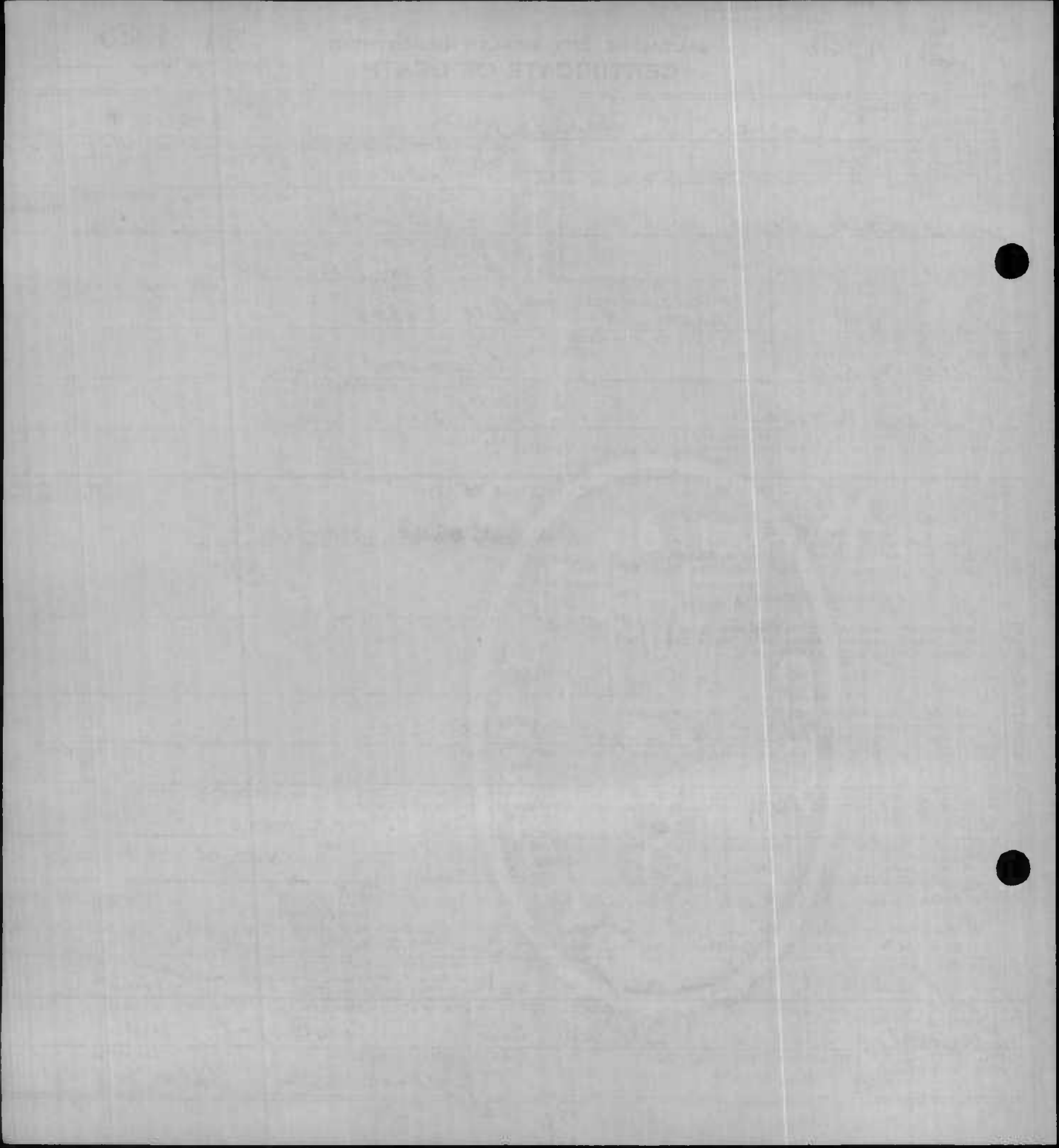
Balto. Md.

VS 151

N-972.0

76086

1790



G-235

50 1926

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1926

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) ABRAHAM GOSTOMELSKY			2. DATE OF DEATH 3-4-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY _____		
5. FULL NAME OF HOSPITAL OR INSTITUTION 42 Swan			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-01		
6. Length of stay in Baltimore 40 Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) 1027 East Baltimore St		
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 6-5		9. AGE (In years, last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY Tailor	11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? ✓
13. FATHER'S NAME Musel			14. MOTHER'S MAIDEN NAME Bellevue		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 1027 East Baltimore St	17. INFORMANT ADDRESS Abraham Gostomelsky		

18. **760 X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Bronchopneumonia, L.L.L.**
DUE TO **Cerebral vascular accident with right hemiplegia**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Diabetes mellitus**
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **2-23**, 19**50**, to **3-4**, 19**50**, that I last saw the deceased alive on **3-3**, 19**50**, and that death occurred at **12:45 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 5 1950

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61

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50 1927

50 1927

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

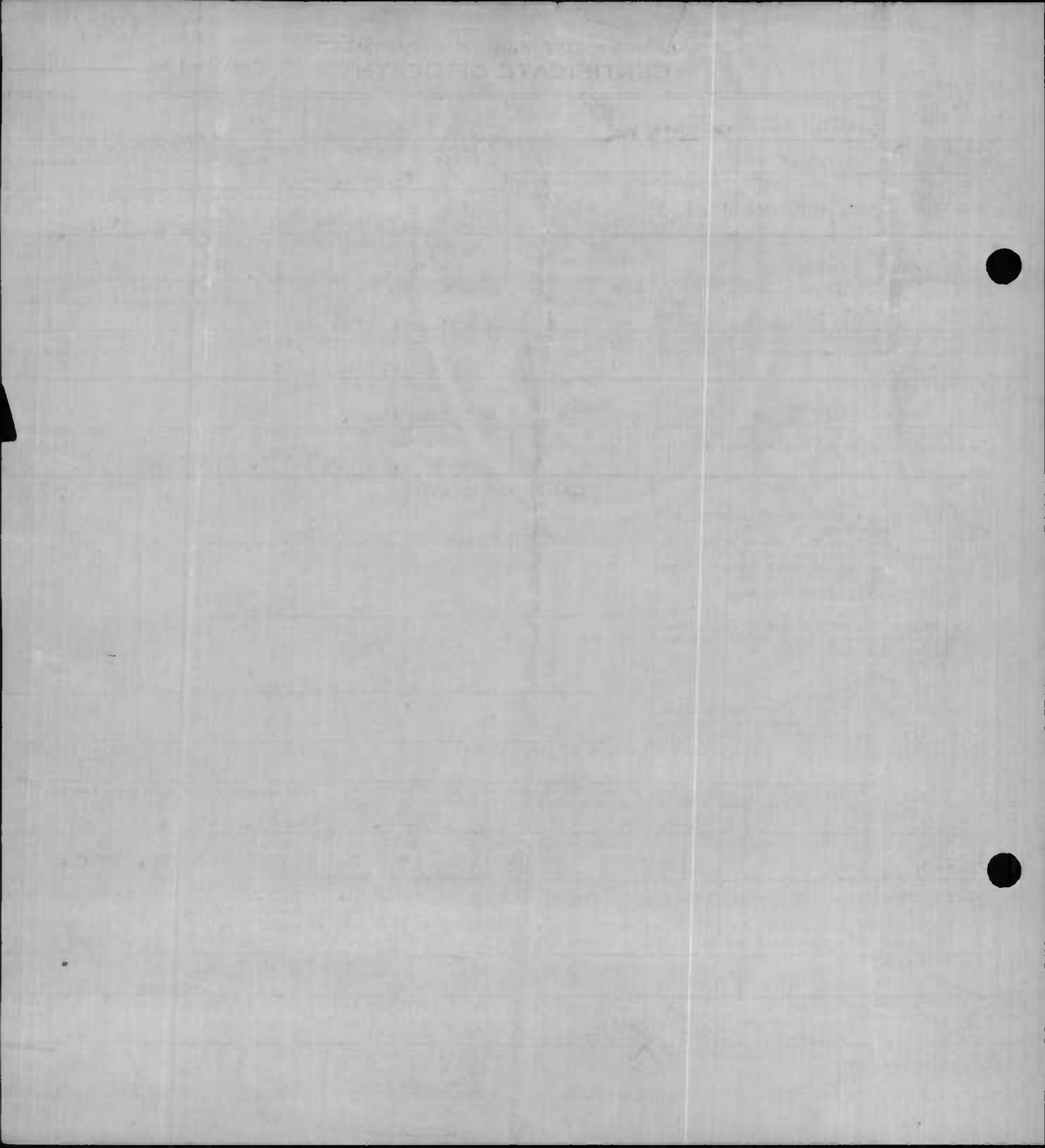
1. NAME OF DECEASED (Type or Print) DOROTHY PAYNE AIKENS LEE		2. DATE OF DEATH March 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 1030 Payson St. (N.)		E. LENGTH OF STAY IN BALTIMORE 16-04	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 14, 1904
9. AGE (In years last birthday) 45		10. UNDER 1 YEAR Months: Days	11. UNDER 24 HOURS Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Payne		14. MOTHER'S MAIDEN NAME Matilda Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Thomas R. Ayers		ADDRESS Towson 2 E. Providence Rd.	

18. E892.0 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Carbon monoxide poisoning DUE TO	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1030 N. Payson St.
21D. TIME (Month) (Day) (Year) (Hour) March 1, 1950 ? m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Coal gas (chimney stopped up, automatic draft stuck)

22. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Carl H. Payne</i>	23B. CHIEF MEDICAL EXAMINER M.D. <i>Carl H. Payne</i>	23C. DATE SIGNED March 1, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) B.	24B. DATE Mar 5 1950	24C. NAME OF CEMETERY OR CREMATORY Pleasant Rest
24D. LOCATION (City, town, or county) (State) Towson Md	25. FUNERAL DIRECTOR Benard Mamie W. Wright	ADDRESS 729 Rosquite St
DATE RECEIVED BY LOCAL REGISTRAR 5-1950	REGISTRAR'S SIGNATURE <i>Benard Mamie W. Wright</i>	



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1928
Registered No. _____

600
50 1928
BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) John Frank Moore		2. DATE OF DEATH 3-2-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY City	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-04	
5. LENGTH OF STAY IN BALTIMORE		D. STREET ADDRESS (If rural, give location) 1521 E. Chase St	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-15-1902
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Oles. Envelope Corp.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME 3		14. MOTHER'S MAIDEN NAME 1	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	

<p>18. 331X</p> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>Antecedent Causes</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p align="center">CAUSE OF DEATH</p> <p>(A) Cerebral Hemorrhage</p> <p>DUE TO</p> <p>(B) Essential Hypertension</p> <p>DUE TO</p> <p>(C) _____</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 3-2-1950 , to 3-2-1950 , that I last saw the deceased alive on 3-2-1950 , and that death occurred at 11:40pm. , from the causes and on the date stated above.				
23A. SIGNATURE S. K. Kaan M. D.		23B. ADDRESS St. Joseph Hospital		23C. DATE SIGNED 3-2-50
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE 3-6-50	24C. NAME OF CEMETERY OR CREMATORY mt Auburn	24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR A. Holstead - 918-		

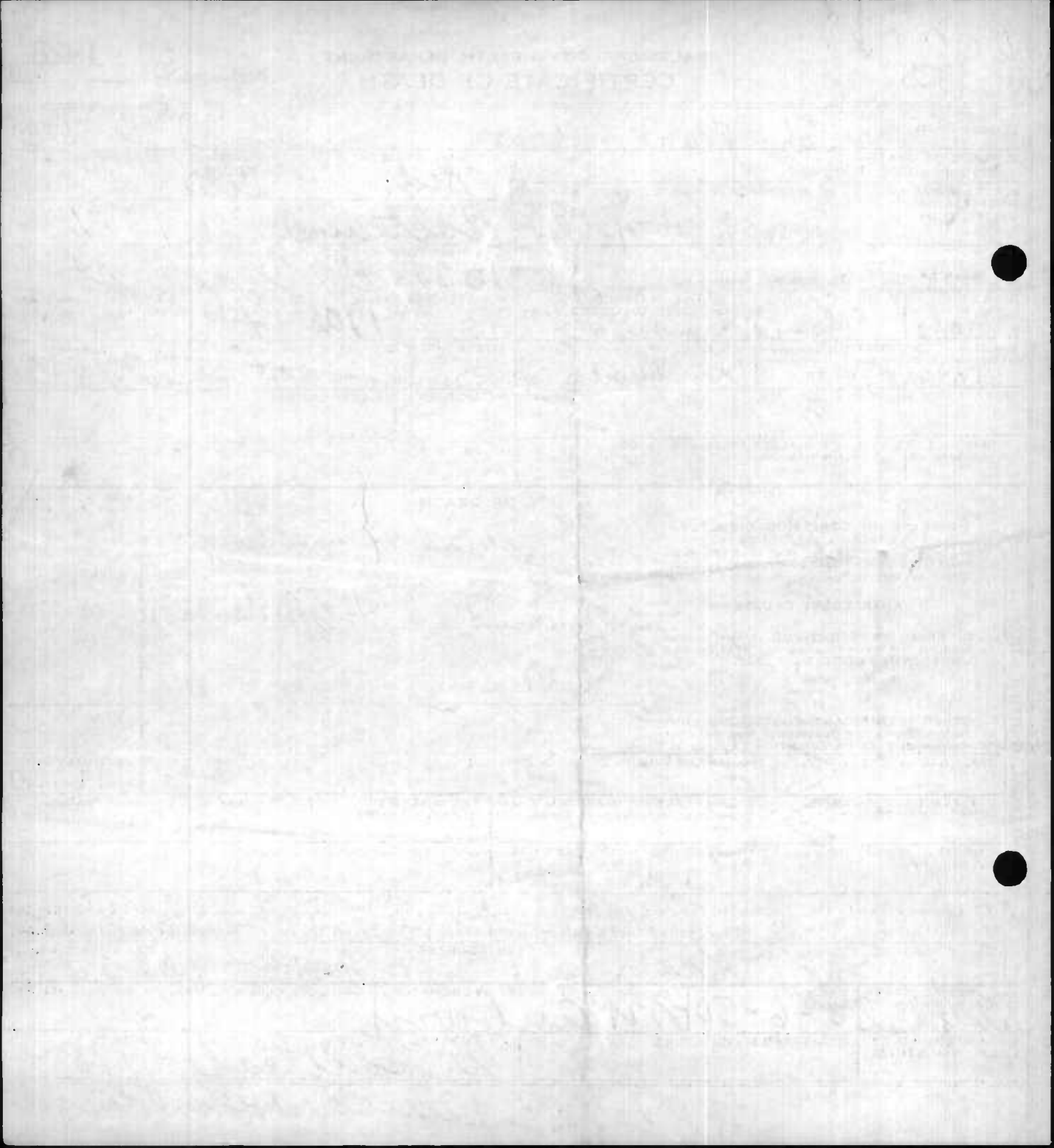
VS 150

988 13

Revised Hill ac 83a

correct age is especially important. In physicians, please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION



435

50 1929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

50 1929

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Wallace, Milton

2. DATE
OF
DEATH

3/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1108 - Russell St.

30 Yrs.
Mos.
Days

Length of stay in Baltimore

5. SEX

M.

6. COLOR OR RACE

Col.

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widower

4. USUAL RESIDENCE (Where deceased lived if institution; residence

A. STATE

B. COUNTY

before admission)

C. CITY OR TOWN

Baltimore 121-01

D. STREET ADDRESS (If rural, give location)

1108 - Russell St.

8. DATE OF BIRTH

10-4-1885

9. AGE (In years;

last birthday)

64

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

unemployed

10B. KIND OF BUSINESS OR INDUSTRY

none

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Lenna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, or if unknown)

no

(If yes, give war or dates of service)

none

16. SOCIAL

SECURITY NO.

none

17. INFORMANT

Lucy Milton - 1108 Russell St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Coronary occlusion

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Arteriosclerotic Cardiac vascular
renal disease

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1949, to 3/2, 1950, that I last saw the deceased alive on 3/2, 1950 and that death occurred at 5 P. M., from the causes and on the date stated above.

23A. SIGNATURE

D. Theophylus M.D.

23B. ADDRESS

600 N. Mount St.

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3-6-50 Mt Auburn

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Milton Wallace

25. FUNERAL DIRECTOR

ADDRESS

A. Halstead - 918 Dr. Hill Ave

VS 150

988 990 1931

131a

MEDICAL CERTIFICATION

64 3523
1950
To the
Honorable
Chairman
of the
Committee
on
Education
and
Labor
U. S. House
of Representatives
Washington, D. C.
Dear Sir:
I am writing to you
in response to your
letter of the 10th
instant regarding
the proposed
amendment to the
National Labor
Relations Act.
I am in complete
agreement with
you that the
present law is
deficient in many
respects and that
it is necessary to
bring it up to date.
I believe that the
proposed amendment
is a good one and
that it will be
beneficial to the
labor movement.
I am sure that you
will find it to be
a most desirable
change.
Very truly yours,
[Signature]

516

TIMBROAK

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1930

Registered No.

50 1930

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>LEOYN TIMBROAK</i>			2. DATE OF DEATH <i>3-4-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>West Va.</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>28 University Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Shanks</i>		
Length of stay in Baltimore <i>One Month</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location)		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec. 1899</i>	9. AGE (In years, last birthday) <i>50</i>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Agricultural</i>	11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Hunter Isaac Timbroak</i>			14. MOTHER'S MAIDEN NAME <i>Cordelia May Snyder</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Allen Timbroak 68A Seversky Ct.</i>		

18. *192X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *Pulmonary Edema*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Brain tumor*
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

*2-14-50**Flowing right parietal lobe*YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *2-7-1950*, to *3-4-1950*, that I last saw the deceased alive on *3-4-1950*, and that death occurred at *7:50 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Pomeroy Nichols**Community Hosp.**3-5-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Removal**MAR. 5, 1950**MT. ZION**AUGUSTA - WEST VIRGINIA*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*MAR 6 - 1950**Thos. J. Hill**WM. COOK INC**1217 ST PAUL ST*

VS 150

000VV 1932

54a

correct age is especially important. Informants: please write the causes of death clearly and legibly.

160

50 1931

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1931

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

COOPER, IRMA

2. DATE
OF
DEATH

3/5/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTE

Provident

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTO

17-01

D. STREET ADDRESS (If rural, give location)

650 George St.

Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

Negro

7. SINGLE MARRIED

WIDOWED DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Henry Turner

8. DATE OF BIRTH

March 17, 1893

9. AGE (In years last birthday)

56

11 Under 1 Year 11 Under 24 Hours

Months: Days Hours: Min.

11. BIRTHPLACE (State or foreign country)

Washington D.C.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Ella Webb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 450.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Undetermined

DUE TO

ANTECEDENT CAUSES

(B)

Uremia

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

Renal failure
arteriosclerosis

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4/50, 1950, to 3/5/50, 1950 that I last saw the deceased alive on 3/5, 1950, and that death occurred at 6:00 A.m., from the causes and on the date stated above.

23A. SIGNATURE

John H. Holmes III

M. D.

23B. ADDRESS

Provident Hosp.

23C. DATE SIGNED

3/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

24B. DATE

3/5/50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

WASH. D.C.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Bernes & Matthews

ADDRESS

614-4th S.W. Washington D.C.

1000
1000
1000

1000
1000
1000

1000
1000
1000

655
50 1932BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1932

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MABEL E. FURMAN

2. DATE

OF

DEATH

March 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1807 Wilhelm St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

(If outside corporate limits, give RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1807 Wilhelm St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 3, 1898

9. AGE (In years
last birthday)

51

If Under 1 Year
Months Days Hours Min10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

At home

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

William Watson

14. MOTHER'S MAIDEN NAME

Cora E. Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

John Furman, 1807 Wilhelm St.

18. 174X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Carcinomatosis

7 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Carcinoma, Uterine

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1949, to Mar, 1950, that I last saw the
deceased alive on 2 Mar, 1950, and that death occurred at 6:58 P.M., from the causes and on the date stated above.

23A. SIGNATURE

H. Bayless

23B. ADDRESS

1600 Wilhelm Ave

23C. DATE SIGNED

5 Mar 50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

Meadow Ridge Memorial

24D. LOCATION (City, town, or county) (State)

Dorsey, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

William Cook, Inc., 1217 St. Paul St.

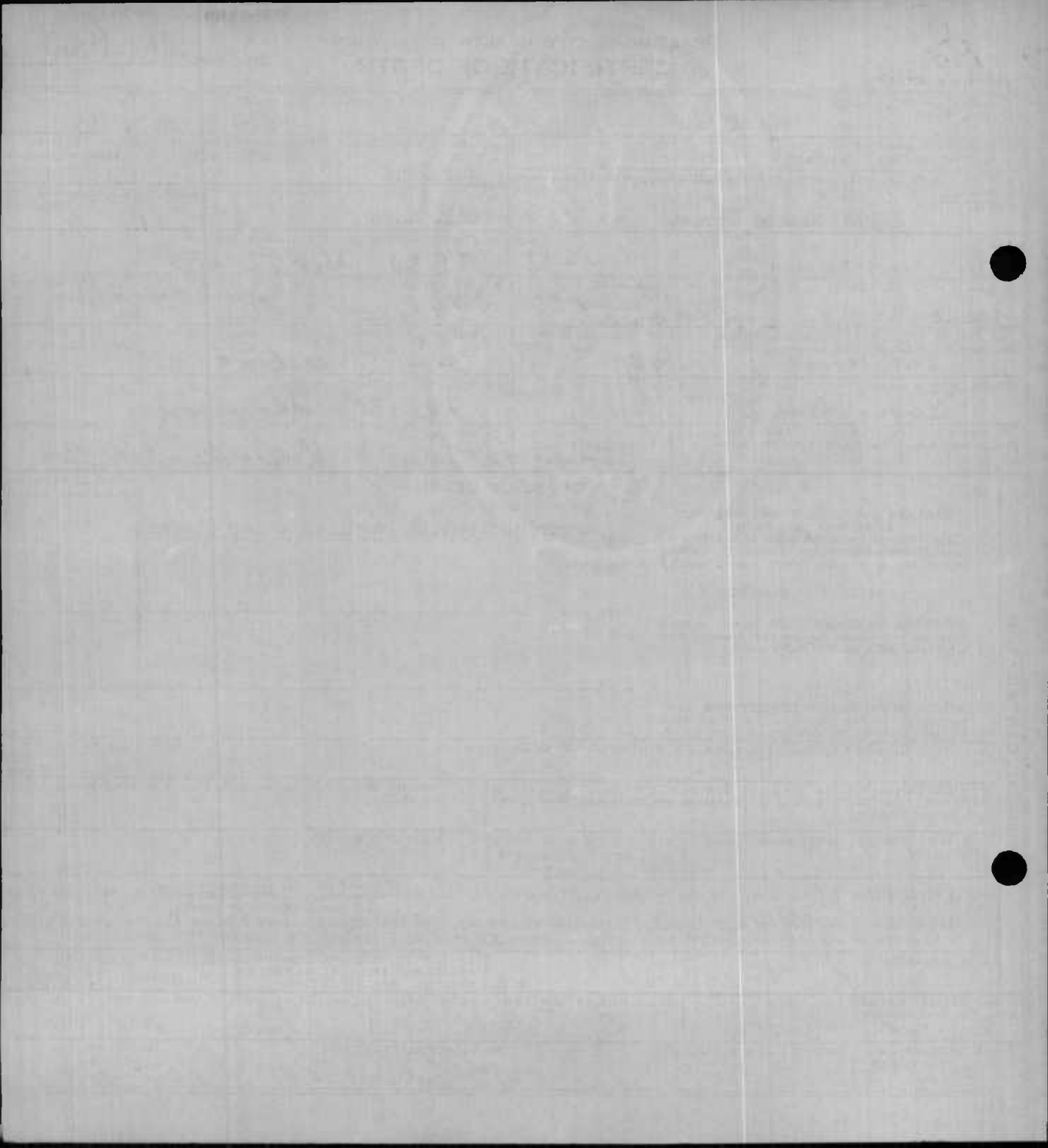
Cook's
1st + Partner

430
50 1933
BIRTH NO. 1933BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1933

1. NAME OF DECEASED (Type or Print) ELMA HOLLIDAY		2. DATE OF DEATH March 3, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 3520 Hilton Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 3520 Hilton St.		15-11	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3/14/1869
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY Sale	9. AGE (In years last birthday) 80
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Smith		14. MOTHER'S MAIDEN NAME Martha Haymon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Catherine Mich		ADDRESS 4614 Mainfield Ave	

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO	
(C)			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
23A. SIGNATURE R S Fisher		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	
23C. DATE SIGNED March 3, 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/6/50	
24C. NAME OF CEMETERY OR CREMATORY St. Peter's		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25. FUNERAL DIRECTOR Wm. C. Inc. 1217 St. Paul St.		ADDRESS	
26. DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		REGISTRAR'S SIGNATURE	



435
50 1934

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1934
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. DELLA DUANE BOLTON		2. DATE OF DEATH 3/4/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MD. B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION Church Home + Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 28, Calverton	
D. STREET ADDRESS (If rural, give location) 104 Woodlawn Ave.		E. Length of stay in Baltimore 36 Yrs. Mos. Days	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 2, 1874
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 75
13. FATHER'S NAME Mr. Timothy Duke		11. BIRTHPLACE (State or foreign country) Ireland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Anne Connors	
17. INFORMANT Mr. Helen Bolton		ADDRESS 4028 E. Dignow	

18. **153X**
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) **Carcinoma of Cecum**
DUE TO

INTERVAL BETWEEN ONSET AND DEATH
6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)
DUE TO

19A. DATE OF OPERATION 3/7/50		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/22 , 19 50 , to 3/4 , 19 50 , that I last saw the deceased alive on 2/4 , 19 50 , and that death occurred at 8 A m., from the causes and on the date stated above.					
23A. SIGNATURE Edna E. Eason		23B. ADDRESS Church Home + Hosp		23C. DATE SIGNED 3/4/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/7/50		24C. NAME OF CEMETERY OR CREMATORY Cathedral	
24D. LOCATION (City, town, or county) Balto, Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		25. FUNERAL DIRECTOR Wm. Cook Inc. 1217 St. Paul st.	

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.



535
50 1935BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1935

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

EVA Genthner

2. DATE
OF
DEATH

MAR 4 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or
location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore, 1-05

C. Length of stay in Baltimore

Yrs.
Mos.
Days

D. STREET ADDRESS (If rural, give location)

212 S. DUNCAN ST.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years,
last birthday)If Under 1 Year
Months Days
If Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Herbert Homf.

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or date of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 551X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Pulmonary embolism?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Coronary thrombosis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Excision of thyroid adenoma 3/2/50

19A. DATE OF OPERATION

3/2/50

19B. MAJOR FINDINGS OF OPERATION

Thyroid adenoma

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-1-1950, to 3-4-1950 that I last saw the
deceased alive on 3-4-1950, and that death occurred at 4:25 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Gordon Malone Carver, Jr.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/4/50

24C. NAME OF CEMETERY OR CREMATORY

St. Peter's

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

MAR 6 - 1950

REGISTRAR'S SIGNATURE

Washington Williams

25. FUNERAL DIRECTOR

Whom (Dr. 1217 H. Paul)

ADDRESS

STATE OF TEXAS
COUNTY OF DALLAS

1
Cora

2

260
50 1936

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1936

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Anna C. Baker

2. DATE
OF
DEATH

march 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

St Balto Gen Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN Baltimore

D. STREET ADDRESS (If rural, give location)

3805 Emerald Ave

C. Length of stay in Baltimore

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

8. DATE OF BIRTH

July 16 1894

9. AGE (In years last birthday)

45

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

(Unknown) Thendroth

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Dorothy M Baker, 3805 Emerald Ave

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pneumonitis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/26/50 to 3/4/50 that I last saw the deceased alive on march 4, 1950 and that death occurred at 6:35 p. m., from the causes and on the date stated above.

23A. SIGNATURE

Jerome Fleet

M. D.

23B. ADDRESS

St. Balto. Gen'l Hosp

23C. DATE SIGNED

march 4, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

buried

24B. DATE

3/8/50

24C. NAME OF CEMETERY OR CREMATORY

St. Ann's

24D. LOCATION (City, town, or county) (State)

Baltimore Co Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

William

William

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50** **1937**

462
50 **1937**
BIRTH NO

1. NAME OF DECEASED (Type or Print) FRANCIS V CLARK		2. DATE OF DEATH March 4, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
Length of stay in Baltimore Life		D. STREET ADDRESS (If rural, give location) 15 E. Lafayette Street	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 25, 1918
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Sheet worker		9. AGE (In years last birthday) 31 If Under 1 Year Months: Days If Under 24 Hours Hours: Min.	
10B. KIND OF BUSINESS OR INDUSTRY Private contractors		11. BIRTHPLACE (State or foreign country) Baltimore	
13. FATHER'S NAME Walton C. Clark		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME Lillian Kavanaugh	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Kavanaugh	
		ADDRESS 327 E. 22th St	

18. E 981. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple gun shot wounds of chest		INTERVAL BETWEEN ONSET AND DEATH
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Cecil & North Avenues
21D. TIME (Month) (Day) (Year) (Hour) March 3, 1950 ? P m.		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Firearms

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, **homicide** ☒, undetermined ☐.

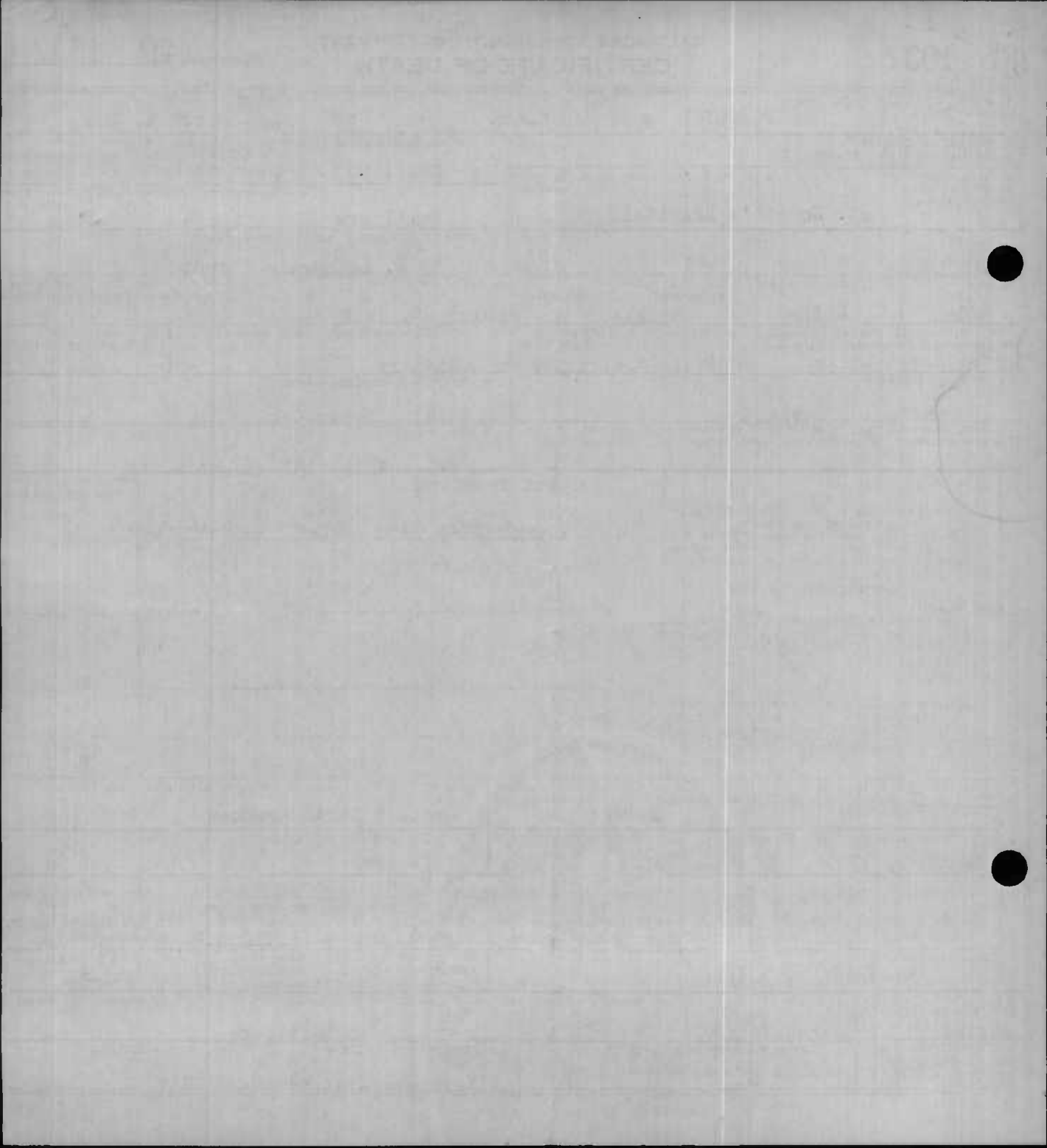
23A. SIGNATURE W. J. McClopperty		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED 3-4-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE March 7th/50	24C. NAME OF CEMETERY OR CREMATORY Cathedral	24D. LOCATION (City, town, or county) (State) Baltimore	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		25. FUNERAL DIRECTOR ADDRESS Rita Wiedefeld 900 E. Biddle St		

N-8124

362V9

166

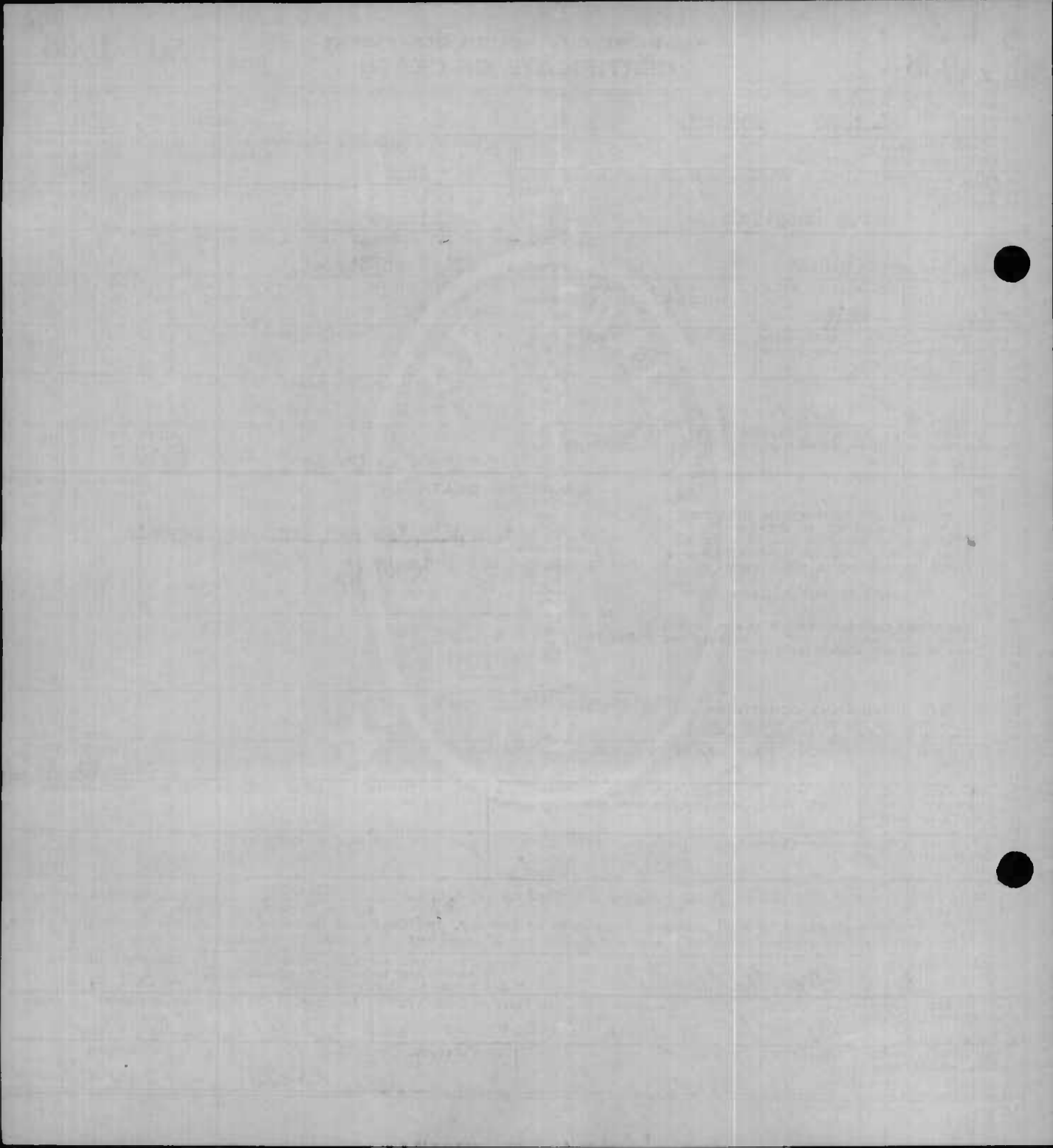
MEDICAL CERTIFICATION



525
50 1938BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1938

1. NAME OF DECEASED (Type or Print) CLEMENS JOHNSON		2. DATE OF DEATH March 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 421 East Street	
5. SEX male	6. COLOR OR RACE white C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 12/25/04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAB-ORER		10B. KIND OF BUSINESS OR INDUSTRY POULTRY	9. AGE (In years last birthday) 45
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ROBERT JOHNSON		14. MOTHER'S MAIDEN NAME MARIA BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT JAMES JOHNSON		ADDRESS 421 EAST ST	
18. 241X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Purulent bronchitis and bronchopneumonia DUE TO bronchial asthma ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE H. J. Mc Clafferty		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	
23C. DATE SIGNED March 2, 1950			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/6/50	
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) A. A. County, Md	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		25. FUNERAL DIRECTOR Joseph H. Locks, Jr. 1304 N. Central	



255
50 1939BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHX
Registered No. 50 1939

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary A. Beckman

2. DATE
OF
DEATH

March 4 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

60 Colonial Nursing & Conv. Home

Yrs.
Mos.
Days

Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

4506 Sorrento Rd.

8. DATE OF BIRTH

Oct. 25 1856

9. AGE (In years)

93

If Under 1 Year

Months: Days: Hours: Min.

4

5

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Martinsburg VA VA

12. CITIZEN OF

U.S. COUNTRY?

13. FATHER'S NAME

James L. Pyne

14. MOTHER'S MAIDEN NAME

Mary Lary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Frank Della Noce 513 Stamford Rd.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1950, to March 4, 1950, that I last saw the deceased alive on February 15, 1950, and that death occurred at 1:00 A. M., from the causes and on the date stated above.

23A. SIGNATURE

James J. Wilson

23B. ADDRESS

M. D. 5804 Edmonson Ave. Balt 28

23C. DATE SIGNED

3/5/50

24A. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

March 7 1950 Holy Redeemer Cem.

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

4430 Belair Rd. Balt. Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Eustigton Williams, Jr.

25. FUNERAL DIRECTOR

Frank Della Noce

ADDRESS

322 S. High St.

MAR 6 - 1950

VS 150

1941

94a

CERTIFICATE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

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200

50 1940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1940

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary Rucci

2. DATE
OF
DEATH

March 2 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 122 S. Exeter St.

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

122 S. Exeter St.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 16 1888

9. AGE (in years-
last birthday)

61

10. Under 1 Year
Months: Days
11. Under 24 Hours
Hours: Min.

3 13

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Vasto Mainland (Italy)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Angelo Di Guglielmo

14. MOTHER'S MAIDEN NAME

Maddalena Monteferando

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Joseph Rucci

122 S. Exeter St.

18. 4222

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

Bronchopneumonia

3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

Chronic Myocarditis

5 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Feb 49, 1950, to 3/2, 1950, that I last saw the deceased alive on 3/1, 1950, and that death occurred at 7:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Morton L. Solomon M. D.

129 S Broadway

3/2/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

March 6 1950

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county) (State)

Cemetery 4430 Belair Rd. Balt. md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

Huntington Williams, Jr.

Frank Della Noce 322 S. High St.

From the house

346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1941

BIRTH NO. 50 1941

1. NAME OF DECEASED (Type or Print) ANNA BUTLER		2. DATE OF DEATH 3/3/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Ma. B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) 121 W Perry st.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-01	
D. STREET ADDRESS (If rural, give location) 121 W Perry st.		E. LENGTH OF STAY IN BALTIMORE 25 Yrs. None Days	
5. SEX Female	6. COLOR OR RACE Col	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Feb-14-1896
9. AGE (In years, last birthday) 54		10. CITIZEN OF WHAT COUNTRY? USA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10B. KIND OF BUSINESS OR INDUSTRY Private Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Maynard		14. MOTHER'S MAIDEN NAME Harriet Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Catherine Myers		ADDRESS 121 W Perry st	

18. **420.1**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

Coronary Thrombosis**5 days**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

Hypertension - Neglected

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec 10, 1949** to **3/3, 1950** that I last saw the deceased alive on **3/3, 1950**, and that death occurred at **7 P. M.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

James A. Stayer

638 N. Gilman

51086

94a

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1942

Registered No. _____

1. NAME OF DECEASED
(Type or Print)

OLIVER

DELKER

2. DATE OF DEATH March 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

South Baltimore General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Glen Burnie

O. STREET ADDRESS (If rural, give location)

Crane Highway, Route #2, Box 6

Length of stay in Baltimore

Yrs.
Mos.
Days

SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 21, 1926

9. AGE (In years last birthday)

24

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Lumber Co.

11. BIRTHPLACE (State or foreign country)

Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY?
US

13. FATHER'S NAME

John Delker

14. MOTHER'S MAIDEN NAME

Marie E. Chrest

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

16. SOCIAL SECURITY NO.

219-16-2341

17. INFORMANT

ADDRESS: Glen Burnie Md

Mrs. Mary Hood; Box 6 Route 2

18. E819.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Crushing injuries of head

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

11

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Anne Arundel Co. Md
Ritchie Highway and Elvaton Road

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
March 4, 1950 2:40 A M

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?
pole
Auto sideswiped auto and into telephone

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Dr. S. F. Echer

M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED
3-4-50

24A. BURIAL, CREMATION, REMOVAL (Specify)
Burial

24B. DATE

March 7, 50

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county)

Glen Burnie, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 8 1950

REGISTRAR'S SIGNATURE

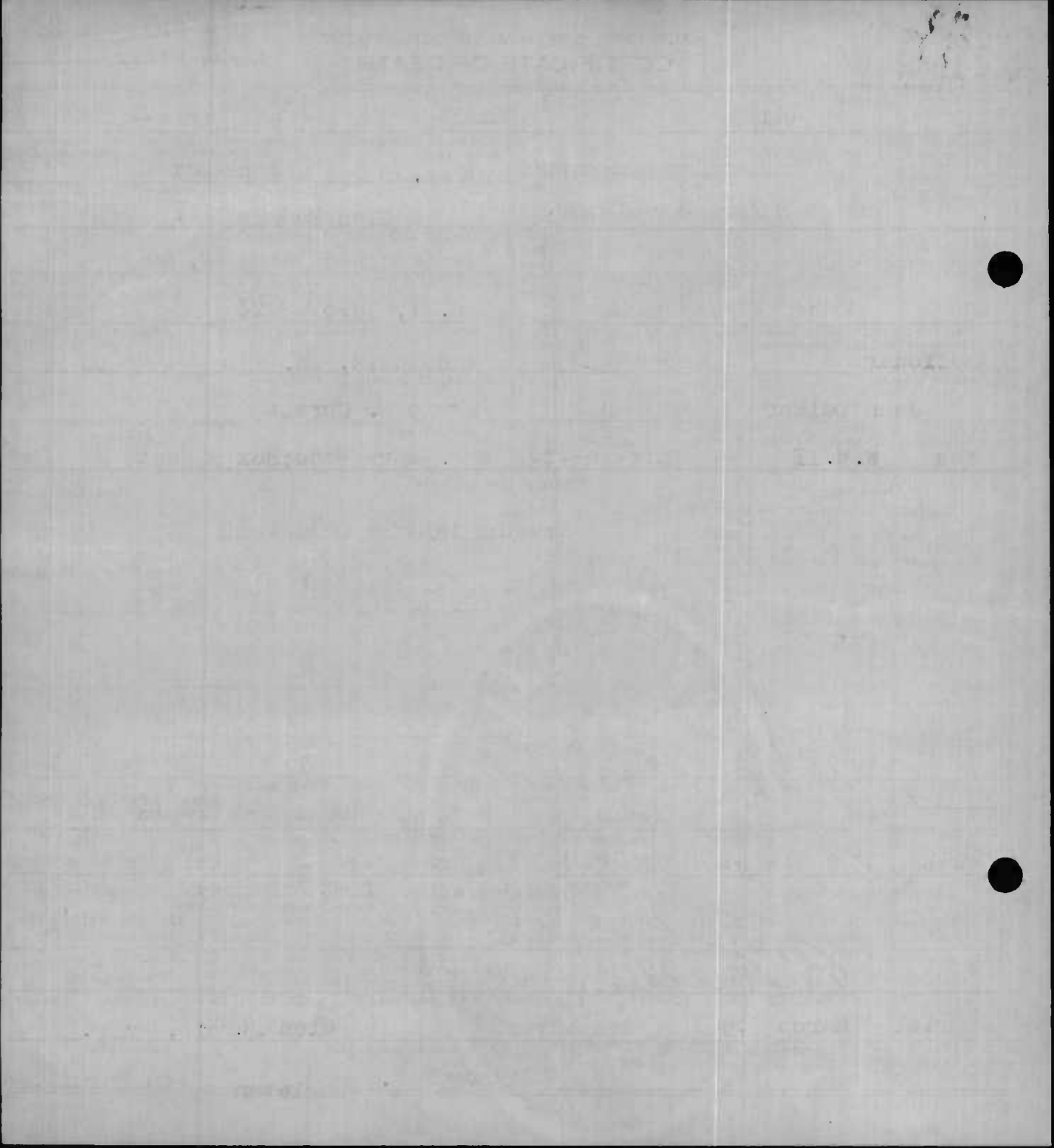
Thomas W. Singleton

25. FUNERAL DIRECTOR

Thomas W. Singleton

ADDRESS

Glen Burnie, Md.



BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

50 1943

BIRTH NO. 350 1943

1. NAME OF DECEASED (Type or Print) Janie Layton		2. DATE OF DEATH March 1, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-04	
D. LENGTH OF STAY IN BALTIMORE 32 Yrs.		E. STREET ADDRESS (If rural, give location) 1030 N. Payson St.	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 20 1900
9. AGE (In years last birthday) 49		10. BIRTHPLACE (State or foreign country) Virginia	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William King		14. MOTHER'S MAIDEN NAME Mary King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Janey King		ADDRESS 920 N. Stricker St	

18. CAUSE OF DEATH E 8920 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Carbon monoxide poisoning DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
---	----------------------------------

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1030 Payson St. (N)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY March 1, 1950 ? m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? automatic draft Coal gas (chimney stepped up, stuck)
22. I certify that I took charge of the remains described above, held an Insp. & Inc. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE <i>Paul L. Royce</i>	23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	23C. DATE SIGNED March 1, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/6/1950	24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.	24D. LOCATION (City, town, or county) (State) Brooklyn A.A.Co.Md.
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		25. FUNERAL DIRECTOR Elroy O. Wilson	
REGISTRAR'S SIGNATURE <i>Paul L. Royce</i>		ADDRESS 1000 Brantly Ave	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of informant

10. Signature of witness

11. Signature of funeral director

12. Signature of undertaker

13. Signature of cemetery

14. Signature of burial

15. Signature of interment

16. Signature of cremation

17. Signature of disposition

18. Signature of remains

19. Signature of crematorium

20. Signature of crematory

21. Signature of cremation

22. Signature of crematorium

23. Signature of crematory

24. Signature of cremation

25. Signature of crematorium

26. Signature of crematory

27. Signature of cremation

28. Signature of crematorium

29. Signature of crematory

50 1944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1944

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELDICA CLARISSA NOVILLE

2. DATE
OF
DEATH

March 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

601 N. Carrollton Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

601 N. Carrollton Ave.

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWER, DIVORCED (Specify)

Widow

Yrs.
Mos.
Days

Length of stay in Baltimore

30 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

13. FATHER'S NAME

John Evans Massiah

8. DATE OF BIRTH

Dec. 24, 1886

9. AGE (in years last birthday)

63

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Trinidad, B.W.I.

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Jane Paris

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT

Miss Isabelle Evelyn N. Carrollton

ADDRESS 601

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

Cerebral hemorrhage

6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

M.hypertension

?

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetis melitis

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 27, 1950, to March 3, 1950, that I last saw the deceased alive on March 3, 1950, and that death occurred at 8:30 P. M., from the causes and on the date stated above.

23A. SIGNATURE

George Mc Donald

M. D.

23B. ADDRESS

844 N. Carey St. Balt. Md.

23C. DATE SIGNED

3/4/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/6/1950

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Memorial Pk. Baltimore Co. Md.

24D. LOCATION (City, town, or county)

(State)

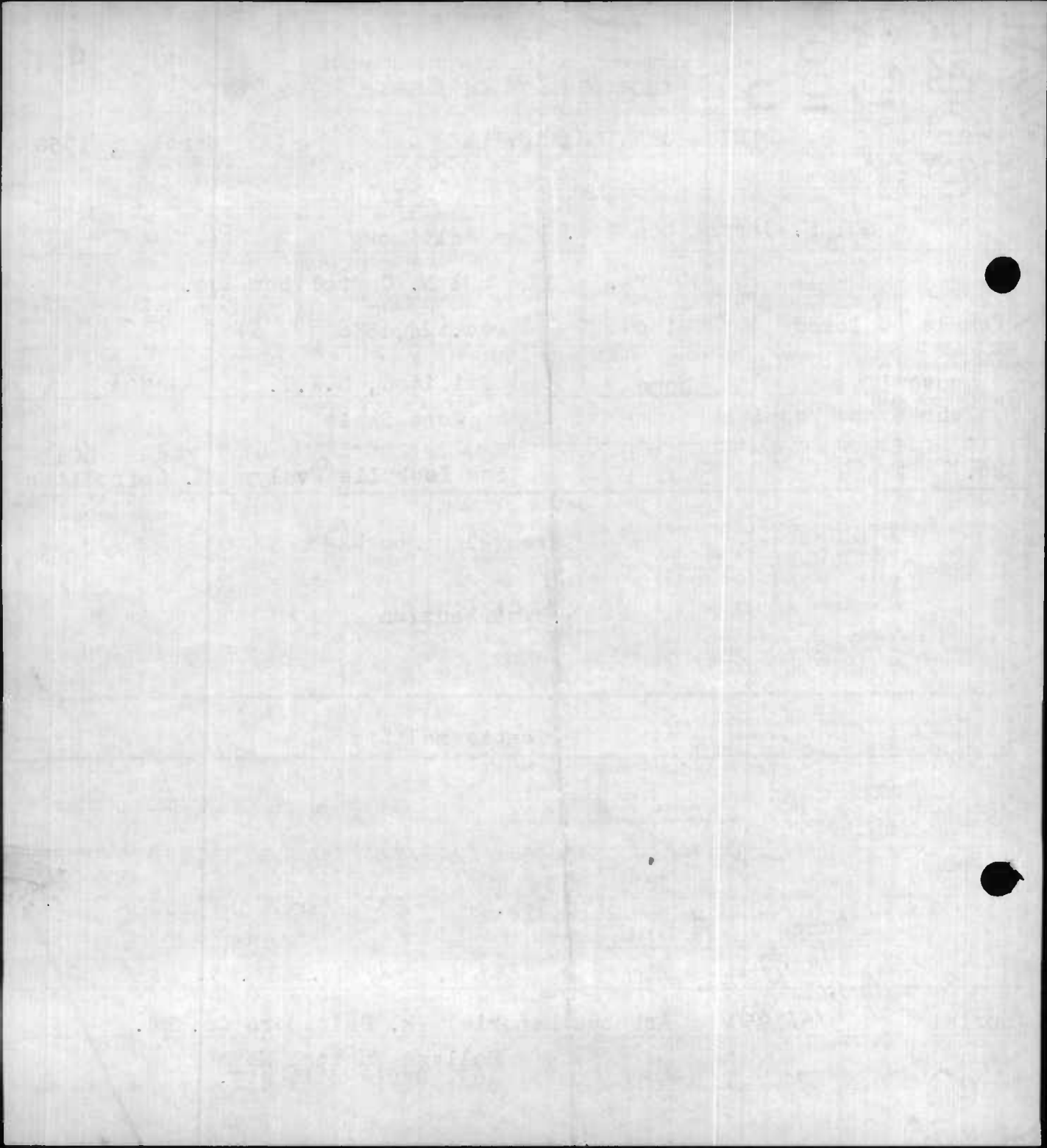
DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

Holland Funeral Home
1631 Druid Hill Ave.

ADDRESS



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1945
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>(JOHN IRWIN WOLLERING)</i> <i>John Irwin Wollering</i>		2. DATE OF DEATH <i>3/2/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore Md 27-09</i>	
D. LENGTH OF STAY IN BALTIMORE <i>Life</i>		E. STREET ADDRESS (If rural, give location) <i>1346 Profton Rd</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widower</i>	8. DATE OF BIRTH <i>April 15 1892</i>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Terminal Manager</i>		9B. KIND OF BUSINESS OR INDUSTRY <i>Penn Railroad</i>	
10. FATHER'S NAME <i>John D. Wollering</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		13. SOCIAL SECURITY NO. <i>717-07-7969</i>	
14. MOTHER'S MAIDEN NAME <i>Rebecca Irwin</i>		15. INFORMANT <i>Apt. C 2710 Yorkway -22</i> <i>John I Wollering</i>	

18. <i>422-1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Anteroselectic C.V. disease</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

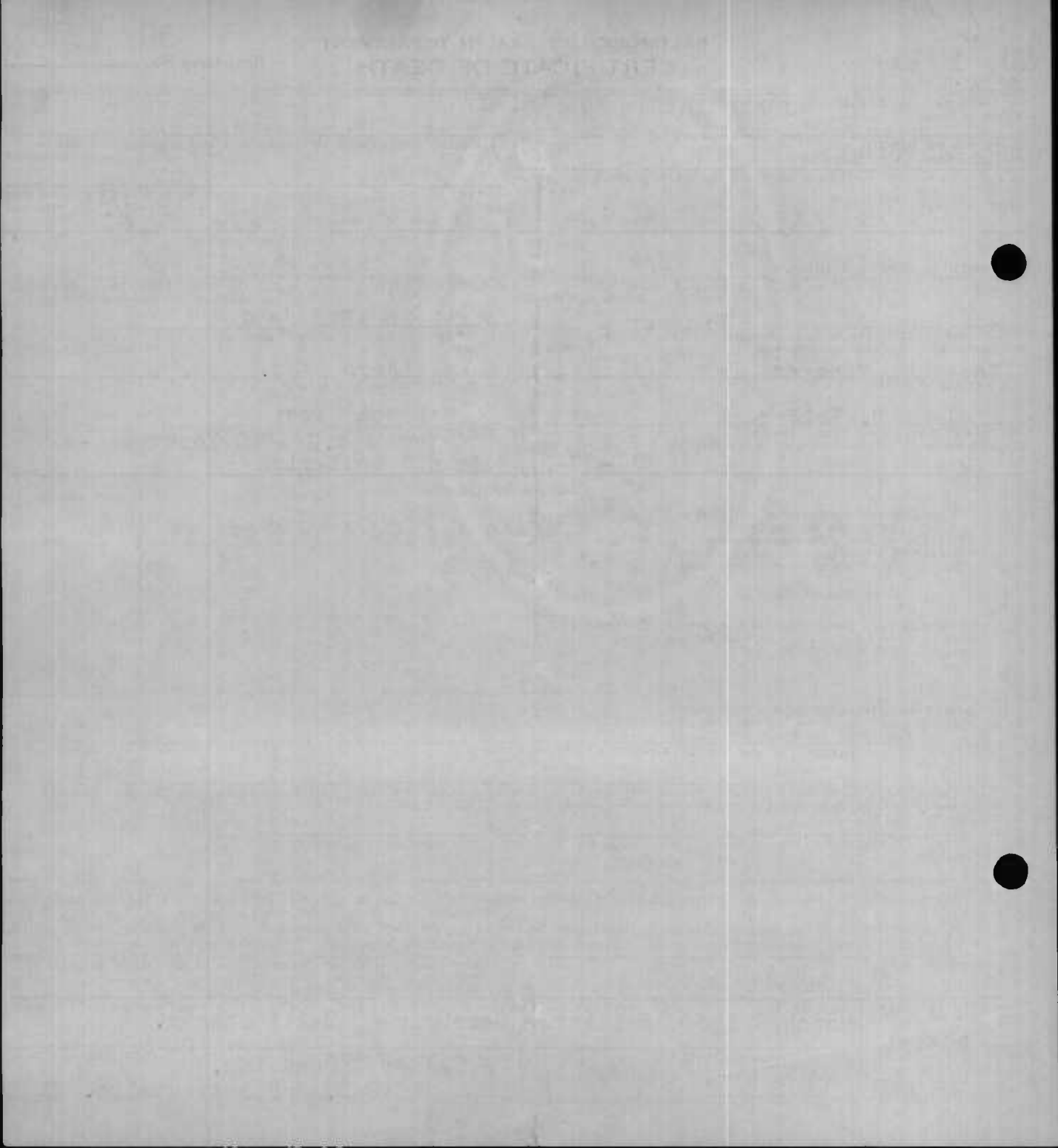
22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE <i>C. J. ...</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <i>3/3/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>March 6 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	

DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 6 - 1950</i>		REGISTRAR'S SIGNATURE <i>...</i>		25. FUNERAL DIRECTOR <i>H. Sander & Sons Inc.</i>		ADDRESS <i>1649 E. North Ave Balto. Md</i>	
---	--	-------------------------------------	--	--	--	---	--

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151 15647 17 937 ✓



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

460

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1946

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) *WILLIAM FRANCIS LAWLER*

2. DATE OF DEATH *March 3, 1950*

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE *Md.* B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore *20-04*

2509 Emerson St.

D. STREET ADDRESS (If rural, give location)
2509 Emerson St.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX *Male* 6. COLOR OR RACE *white* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *married*

8. DATE OF BIRTH *Aug 16, 1877* 9. AGE (In years, last birthday) *72* 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Retired* 10B. KIND OF BUSINESS OR INDUSTRY *Paper City*

11. BIRTHPLACE (State or foreign country) *Penna* 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *John Lawler*

14. MOTHER'S MAIDEN NAME *Catherine Crowley*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS *Mrs Rose Lawler 2509 Emerson St*

18. *0123*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Bronchopneumonia*
DUE TO *(not pulmonary tuberculosis)*

7 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Multiple draining tuberculous sinuses*
DUE TO *left upper extremity and neck, glandular tuberculosis, anguina*
(C) *an tuberculous osteomyelitis left thumb*

2 1/2 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *June 1947*

19B. MAJOR FINDINGS OF OPERATION *Tuberculous osteomyelitis left thumb, glandular tb.*

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Oct*, 1947, to *March 3*, 1950, that I last saw the deceased alive on *March 3*, 1950, and that death occurred at *6:30* m., from the causes and on the date stated above.

23A. SIGNATURE *L. G. Sullivan*

23B. ADDRESS *1114 St Paul St*

23C. DATE SIGNED *Mar 3, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*

24B. DATE *3.7.50*

24C. NAME OF CEMETERY OR CREMATORY *New Cathedral*

24D. LOCATION (City, town, or county) *Baltimore Md*

(State)

DATE RECEIVED BY LOCAL REGISTRAR *MAR 6 - 1950*

REGISTRAR'S SIGNATURE *William H. Williams*

25. FUNERAL DIRECTOR *Harry H. Witke*

ADDRESS *440' Edmondson Ave*

CERTIFICATE OF DEATH

STATE OF NEW YORK

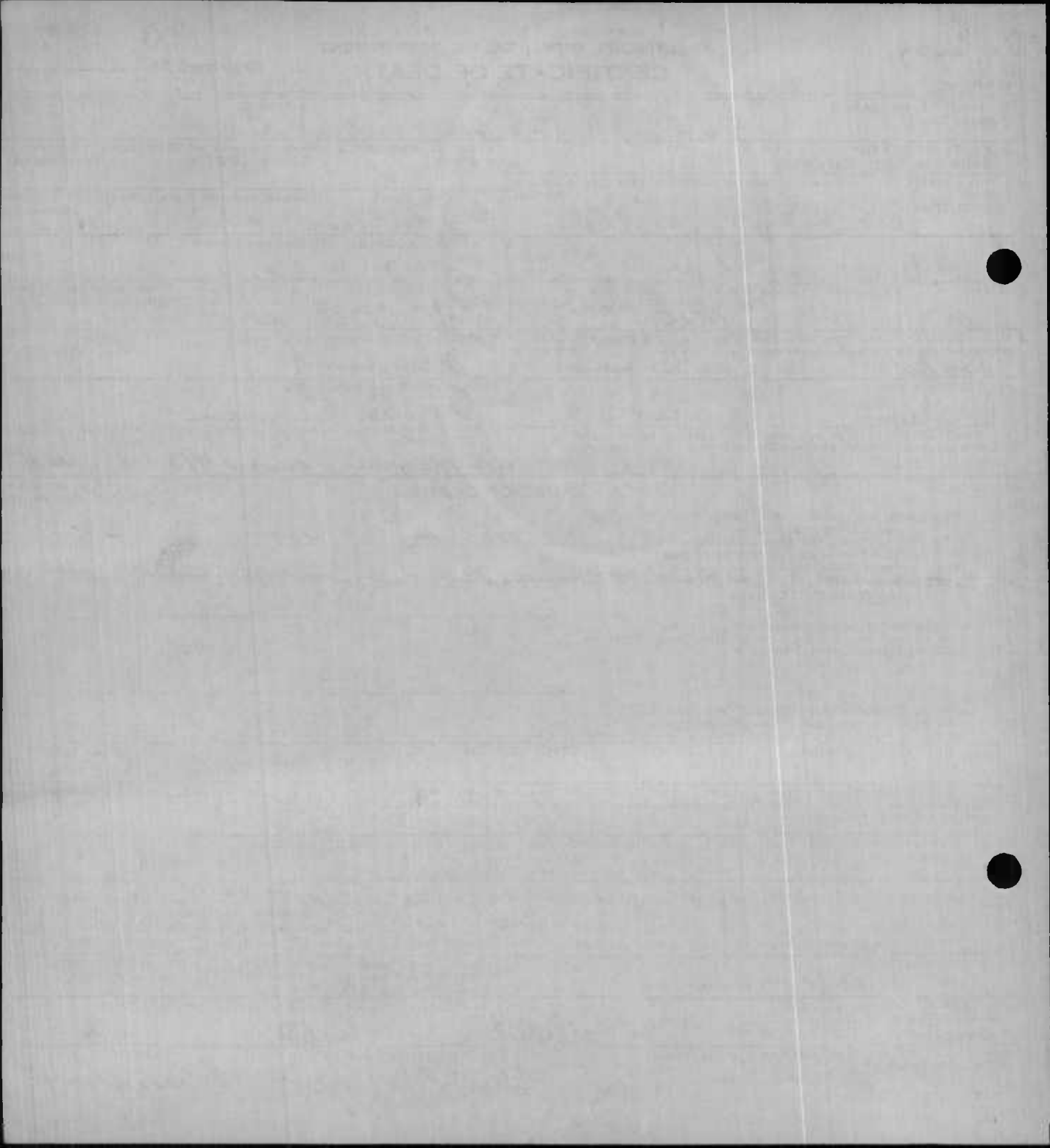
1-1-19

1-1-19

50 1947
536
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1947
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Harmon V. Sanders</i>			2. DATE OF DEATH <i>3/9/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Box 50 Cases Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore MD 20-03</i>		
D. STREET ADDRESS (If rural, give location) <i>413 S. Payson</i>					
Length of stay in Baltimore <i>Life</i>			Yrs. Mos. Days		
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 1888</i>	9. AGE (In years last birthday) <i>61 years 11</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Business</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>William Sanders</i>			14. MOTHER'S MAIDEN NAME <i>Agnes Sugman</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mrs Mammie Sanders</i>			ADDRESS <i>413 S. Payson St.</i>		

18. <i>470.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) <i>Coronary Disease</i>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C)					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>C. J. [illegible]</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... <i>3/9/50</i>		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>3. 7. 50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) <i>Balto.</i>		24E. FUNERAL DIRECTOR <i>Harry H. Wicke</i>		24F. ADDRESS <i>401 Edmondson Ave</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>William [illegible]</i>		25. FUNERAL DIRECTOR <i>Harry H. Wicke</i>	



500
50 1948BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1948
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE H. KAMM

2. DATE
OF
DEATH

MARCH 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 1721 W. FAYETTE ST

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

MARYLAND BALTO

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE 19-02D. STREET ADDRESS (If rural, give location)
1721 W. FAYETTE STREET

C. Length of stay in Baltimore 180

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

12/15/68
DEC 15, 18689. AGE (In years,
last birthday)

82

10 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

CABINET MAKER

10B. KIND OF BUSINESS OR
INDUSTRY

1500 pers Co.

11. BIRTHPLACE (State or foreign country)

WASH. D.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY KAMM

14. MOTHER'S MAIDEN NAME

BORGED

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-09-4411A

17. INFORMANT

ADDRESS

WIFE

1721 W. FAYETTE ST.

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Myocarditis, chronic due to
arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis, generalized

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 11, 1949, to March 4, 1950, that I last saw the deceased alive on March 4, 1950, and that death occurred at 10:45 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Ernie B. Kernick

M. D.

23B. ADDRESS

2356 Annapolis Ave

23C. DATE SIGNED

3/4/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3.7.50

24C. NAME OF CEMETERY OR CREMATORY

London Park

24D. LOCATION (City, town, or county) (State)

Balto Md

DATE RECEIVED BY
LOCAL REGISTRAR

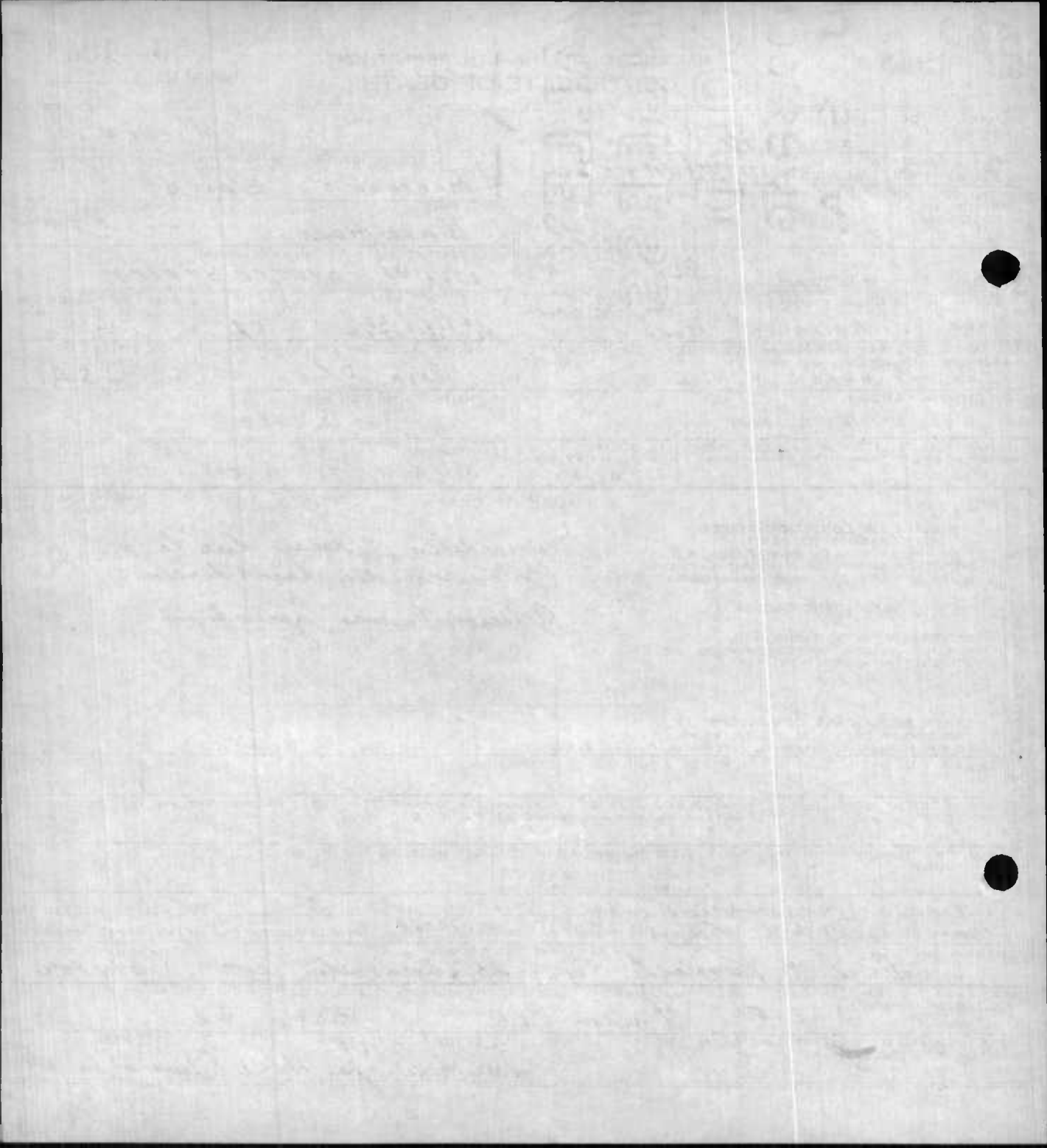
REGISTRAR'S SIGNATURE

MAR 6 1950

25. FUNERAL DIRECTOR

ADDRESS

Harry H. Witzke 4101 Edmondson Ave



125
50 1949BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1949
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ethel Rittenhouse Gibson		2. DATE OF DEATH March 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 2606 Elsinor Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY none	
B. FULL NAME OF HOSPITAL OR INSTITUTION 00		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-08A	
length of stay in Baltimore 50 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 2606 Elsinor Ave.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 7 - 23 - 1871
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Howard Co., Md.	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert A. Rittenhouse		14. MOTHER'S MAIDEN NAME Eliza A. Rhodes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Clifton M. Gibson - 725 Shadeland Ave.		ADDRESS	

18. **331X** I CAUSE OF DEATH **Drexel Hill, PA** BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) **Cerebral hemorrhage.**
DUE TO**15 min**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Artia Sclerosis**
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1 - 1**, 19**49**, to **3 - 2 -**, 19**50**, that I last saw the deceased alive on **3 - 2 -**, 19**50**, and that death occurred at **1 P.m.**, from the causes and on the date stated above.23A. SIGNATURE **Frank J. Warner** M. D. 23B. ADDRESS **2604 Garrison Blvd.** 23C. DATE SIGNED **3 - 4 - 50**

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3 - 6 - 50	24C. NAME OF CEMETERY OR CREMATORY Loudon Park	24D. LOCATION (City, town, or county) (State) Baltimore, Md.
--	--------------------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950	REGISTRAR'S SIGNATURE John O. Mitchell	25. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl.	ADDRESS 83a
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CENTRAL BANK OF INDIA

1931

1 - 22 - 1931

1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

1 - 22 - 1931

-362
50 1950BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1950
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Catherine A. Stricker (STRICKER)

2. DATE
OF
DEATH

3/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

42 Swan Hospital

Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

M

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Clothes Seamstress

10B. KIND OF BUSINESS OR
INDUSTRY

Clothing Mfg.

13. FATHER'S NAME

Thomas Hughes

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-05-8711

17. INFORMANT

James A. Stricker 511 Madison

ADDRESS

18. 491X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Bilateral Mucous Broncho-
pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Rheumatic Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/3, 1950, to 3/4, 1950, that I last saw the
deceased alive on 3/4, 1950, and that death occurred at 10:15 PM., from the causes and on the date stated above.

23A. SIGNATURE

Leon Elaville M. D.

23B. ADDRESS

Swan Hospital

23C. DATE SIGNED

3/5/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Mar 8/50

24C. NAME OF CEMETERY OR CREMATORY

Cath Saint Ann

24D. LOCATION (City, town, or county) (State)

Baltimore

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Catherine Williams

25. FUNERAL DIRECTOR

Philip Horwitz 2020 Orleans St

ADDRESS

VS 150

49606 952

9513

~~213-05-8711~~

621
1951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1951

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRED LEWIS KRICKBAUM

2. DATE
OF
DEATH

Mar. 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR 221 S. Monroe St.
INSTITUTION

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Md.
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 19-04

D. STREET ADDRESS (If rural, give location)
221 S. Monroe St.

Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
married

8. DATE OF BIRTH

May 9, 1896

9. AGE (In years
last birthday)

53

If Under 1 Year Months: Days
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Baker

10B. KIND OF BUSINESS OR INDUSTRY
Bakery

11. BIRTHPLACE (State or foreign country)
Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Krickbaum

14. MOTHER'S MAIDEN NAME

Jennie Selfridge

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.
216-01-7951

17. INFORMANT

ADDRESS

Mr. Raymond L. Krickbaum 306 S. Monroe St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis
DUE TO Coronary Artery Sclerosis

3 days
3 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis
DUE TO Emphysema, Chronic
Bronchitis

3 yrs
3 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Pneumonia

3 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/26/1947 to Jan., 1950, that I last saw the deceased alive on Jan., 1950, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

T. Kneecity

23B. ADDRESS

M. D.

244 N. Helton St.

23C. DATE SIGNED

3/3/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

Kouidon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

MAR 6 - 1950

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.

MEDICAL CERTIFICATION

260
50 1952BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1952
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FLORENCE HOOKER

2. DATE
OF
DEATH

March 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

1127 E. North Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1127 E. North Ave.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

April 12, 1874

9. AGE (In years
last birthday)

75

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John T. Knobloch

14. MOTHER'S MAIDEN NAME

Emma Butzler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. H. Mitchell Hooker 1127 E. North Ave.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

Coronary Occlusion

Several Days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

Arteriosclerotic C-v. Disease

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1946 to March 1st, 1950, that I last saw the deceased alive on March 1st, 1950, and that death occurred at 2:55 p.m., from the causes and on the date stated above.

23A. SIGNATURE

William H. Lustig

M. D.

23B. ADDRESS

112 E. Chase St., Balto.

23C. DATE SIGNED

3-3-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER & SONS

Balto., Md.

CERTIFICATE OF DEATH

1951

1951

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453
50 1953BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1953
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Schlantz, Arthur Albert

2. DATE
OF
DEATH

3/5/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

U.S. Marine Hosp

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

27-06

D. STREET ADDRESS (If rural, give location)

2816 Christopher Ave.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

8/24/90

9. AGE (In years
last birthday)

59

10. Under 1 Year
Months Days11. Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

Unk

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Henry Schlantz

14. MOTHER'S MAIDEN NAME

Anna Leverman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL
SECURITY NO.

Unk

17. INFORMANT

ADDRESS

Medical Records, USMH Balto., Md.

18. 416 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Cardiac disease

12 yrs.

DUE TO Rheumatic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Cardiac failure

2 wks.

DUE TO Pulmonary congestion

Unk

(C) Cirrhosis (splenic congestion)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.19A. DATE OF OPERATION
none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)
none21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK

22. I hereby certify that I attended the deceased from Feb. 14, 1950, to March 3, 1950, that I last saw the deceased alive on March 5, 1950, and that death occurred at 120 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Lergitum D.O.

23B. ADDRESS

USMH Balto., Md.

23C. DATE SIGNED

3/5/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Removal

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

Forest Hill Cem.

24D. LOCATION (City, town, or county)

Dunmore, Pa.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

WM. J. TICKNER & SONS

Balto., Md.

VS 150

98899 1055

95B

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,
January 1, 1910.

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE

FOR THE YEAR 1909.

ALBANY:

1910.

PRINTED BY THE STATE PRINTING OFFICE.

100

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ALBANY:

1910.

PRINTED BY THE STATE PRINTING OFFICE.

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160

50 1954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. _____

50 1954
BIRTH NO.

1. NAME OF DECEASED (Type or Print) HOWIE SHAPIRO			2. DATE OF DEATH 3-5-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY _____		
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2437 West North Ave Baltimore 15-09			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
6. Length of stay in Baltimore 43 Yrs. 43 Mos. 43 Days			D. STREET ADDRESS (If rural, give location) 3924 Furview Ave		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH	9. AGE (In years: last birthday) 53	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Cigar		11. BIRTHPLACE (State or foreign country) Russian	
13. FATHER'S NAME David			14. MOTHER'S MAIDEN NAME Esther		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Rose Dwyer 2437 W. North Ave	

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Myocarditis DUE TO (B) Arteriosclerosis DUE TO (C) As Renia	INTERVAL BETWEEN ONSET AND DEATH
--	--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to March 5, 1950, that I last saw the deceased alive on March 4, 1950, and that death occurred at 9 PM, from the causes and on the date stated above.					
23A. SIGNATURE N. E. Needle M. D.		23B. ADDRESS 2314 - 20. North Tr		23C. DATE SIGNED 3/6/50.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-6-50		24C. NAME OF CEMETERY OR CREMATORY Rosedale	
24D. LOCATION (City, town, or county) Balto Md		25. FUNERAL DIRECTOR ADDRESS Jack Lewis Inc 2100 Canton Pl			

Needle
2314 W North
Ma 6648

534
50 1955
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1955

1. NAME OF DECEASED (Type or Print) ANNA HANDLER		2. DATE OF DEATH 3-6-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution) 3320 Auchentoroly Terrace Baltimore		C. CITY OR TOWN (If outside corporate limits, write R.R. No. and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 3320 Auchentoroly Terrace		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 7-9
9. AGE (In years last birthday) 79		10. CITIZEN OF WHAT COUNTRY? Russian	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Not Known	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Murley Leamer		ADDRESS 7120 Park Hgts. Av.	
18. 334X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Generalized cerebral arteriosclerosis		CAUSE OF DEATH Generalized cerebral arteriosclerosis	
19. 334X DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Heart block, complete		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20. 334X OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH 3 days	
21. DATE OF OPERATION		22. MAJOR FINDINGS OF OPERATION	
23. ACCIDENT, SUICIDE, HOMICIDE (Specify) No		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
25. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		26. TIME (Month) (Day) (Year) (Hour) OF INJURY	
27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		28. HOW DID INJURY OCCUR?	
29. I hereby certify that I attended the deceased from 1/6 , 19 50 , to 3/6 , 19 50 , that I last saw the deceased alive on 3/5 , 19 50 , and that death occurred at 12:54 p.m., from the causes and on the date stated above.			
30. SIGNATURE Samuel Monson		31. ADDRESS 11 E. Chase St. (2)	
32. DATE 3-6-50		33. DATE SIGNED 3/6/50	
34. BURIAL, CREMATION, REMOVAL (Specify) Removal		35. NAME OF CEMETERY OR CREMATORY Hebrew Hebrew Burial	
36. DATE 3-6-50		37. LOCATION (City, town, or county) (State) Balto Md	
38. DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		39. REGISTRAR'S SIGNATURE Frederick Williams	
40. FUNERAL DIRECTOR Jack Lewis		41. ADDRESS 2100 Easton Rd	

Sam Morrison
116 Chase

~~120044~~

~~3/21~~

~~Paul~~
~~Tue 7/12~~

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1956

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Gustave August Gaertner		2. DATE OF DEATH MAR. 5/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland 808 McAllen Ct.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 808 McAllen Ct. Balto Md B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION 808 McAllen Ct.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 808 McAllen Ct		E. LENGTH OF STAY IN BALTIMORE Life	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11/24/1880
9. AGE (in years last birthday) 69		10. Under 1 Year Months: Days	
11. Under 24 Hours Hours: Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Gaertner		14. MOTHER'S MAIDEN NAME Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 216 00-7366	
17. B. SOCIAL SECURITY NO. 216 00-7366		18. B. SOCIAL SECURITY NO. 216 00-7366	
19. B. SOCIAL SECURITY NO. 216 00-7366		20. B. SOCIAL SECURITY NO. 216 00-7366	

18. 610X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cardiac failure Myocardial infarction Arteriosclerosis	CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) prostate enlargement (operation) 5/20/49	INTERVAL BETWEEN ONSET AND DEATH 7 months 8 months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 5/20/49	19B. MAJOR FINDINGS OF OPERATION Rupture of bladder - B.P.H.	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 4/14 , 19 49 , to 3/5/50 , 19 50 , that I last saw the deceased alive on 3/4 , 19 50 , and that death occurred at 4 A.M. , from the causes and on the date stated above.		
23A. SIGNATURE H. W. Munchy	23B. ADDRESS 801 Buren St.	23C. DATE SIGNED 3/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE March 7-50	24C. NAME OF CEMETERY OR CREMATORY Balto Cem	24D. LOCATION (City, town, or county) (State) Balto Md
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 1950	REGISTRAR'S SIGNATURE Wm. J. Williams	25. FUNERAL DIRECTOR Joe J. Herr + Son	ADDRESS 3001 Kentucky Ave

10-1

tenhant

523
50 1957

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1957

Registered No. _____

BIRTH NO. _____

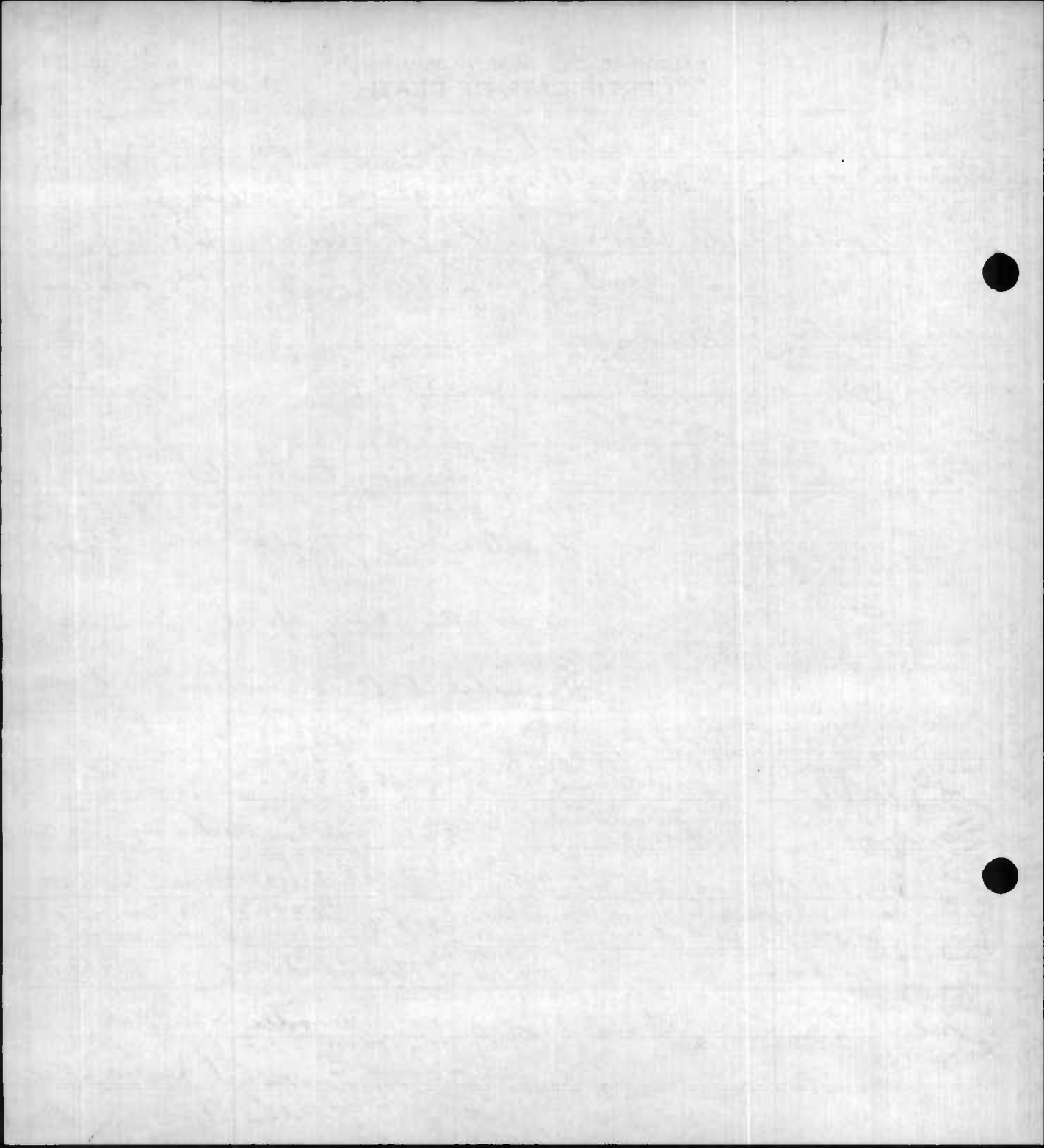
1. NAME OF DECEASED (Type or Print) <i>Josephine Constantinides</i>		2. DATE OF DEATH <i>March 2, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2816 Northern Parkway</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2816 Northern Parkway</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-07</i>	
Length of stay in Baltimore <i>37 years</i>		D. STREET ADDRESS (If rural, give location) <i>2816 Northern Parkway</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE (MARRIED, WIDOWED, DIVORCED) (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>85</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY —	
13. FATHER'S NAME <i>Theodore</i>		12. CITIZEN OF WHAT COUNTRY? <i>Turkey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
11. BIRTHPLACE (State or foreign country) <i>Turkey</i>		12. CITIZEN OF WHAT COUNTRY? <i>Turkey</i>	
17. INFORMANT <i>James Constantinides</i>		ADDRESS <i>2816 Northern Parkway</i>	

MEDICAL CERTIFICATION	18. <i>E903.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO	(A) <i>Fractured hip, right</i>	INTERVAL BETWEEN ONSET AND DEATH <i>3 mos.</i>
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO	(B) <i>Decubitus ulcers, infected</i>	<i>2 mos.</i>
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO	(C) <i>Generalized Arteriosclerosis</i>	<i>?</i>
	CERTIFICATION APPROVED BY <i>P. H. [Signature]</i>		

19A. DATE OF OPERATION <i>12/4/49</i>		19B. MAJOR FINDINGS OF OPERATION <i>Fractured hip, right</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>accident</i>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>2816 Northern Parkway Zone 14</i>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Dec. 4 1949</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>Fell Slipped and fell to floor</i>		
22. I hereby certify that I attended the deceased from <i>Dec. 6, 1949</i> to <i>March 2, 1950</i> , that I last saw the deceased alive on <i>March 2, 1950</i> , and that death occurred at <i>5:00 p.m.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <i>6217 Harford Rd</i>		23C. DATE SIGNED <i>3/3/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>3/6/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Greek Orthodox</i>	24D. LOCATION (City, town, or county) (State) <i>Woodlawn, Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 6 - 1950</i>		25. FUNERAL DIRECTOR <i>Lambros Funeral Home Inc</i>		
REGISTRAR'S SIGNATURE <i>[Signature]</i>		ADDRESS <i>440 E. North Ave 186a</i>		

VS 150

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JL- 135708
50-1958
BIRTH NO. 1958BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1958

1. NAME OF DECEASED (Type or Print) NICHOLAS CHRIST			2. DATE OF DEATH 3-4-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
D. STREET ADDRESS (If rural, give location) 525 S. Newkirk Ave.			E. LENGTH OF STAY IN BALTIMORE 30 yrs.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 27, 1894	9. AGE (In years last birthday) 55	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Helper			10B. KIND OF BUSINESS OR INDUSTRY Restaurant		
13. FATHER'S NAME Manuel Christ			14. MOTHER'S MAIDEN NAME Stanatai Pauaou		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 131-05-5685		
17. INFORMANT B. C. H. Records, 4940 Eastern Ave			ADDRESS		

18. 600.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Uremia DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic Pyelonephritis DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 2-12 , 19 50 , to March 4 , 19 50 , that I last saw the deceased alive on March 4 , 19 50 , and that death occurred at 3.30AM , from the causes and on the date stated above.				
23A. SIGNATURE O. S. Orogen	M. D.	23B. ADDRESS 4940 Eastern Ave.	23C. DATE SIGNED 3-4-1950	

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3-7-50	24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Woodlawn Md.	24D. LOCATION (City, town, or county) (State) 4401 E. North Ave 133a
DATE RECEIVED BY LOCAL REGISTRAR MAR 8 1950	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR Sambros Funeral Home Inc	ADDRESS

(1970-1-1)

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435
50 1959SLAYTON
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1959
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Charles C Slayton</i>			2. DATE OF DEATH <i>3/5/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Anne Arundel</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Annapolis Md</i>		
Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>112 Gloucester St</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 17, 1887</i>		9. AGE (In years last birthday) Months: Days <i>62 83 62</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Captain</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>U.S. Navy</i>		11. BIRTHPLACE (State or foreign country) <i>Springfield, Ohio</i>
13. FATHER'S NAME <i>George A. Slayton</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War 1 and 2</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Commander Morgan Slayton, U.S.N., Annapolis</i>	

18. <i>470.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Disease</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Coronary Disease</i> DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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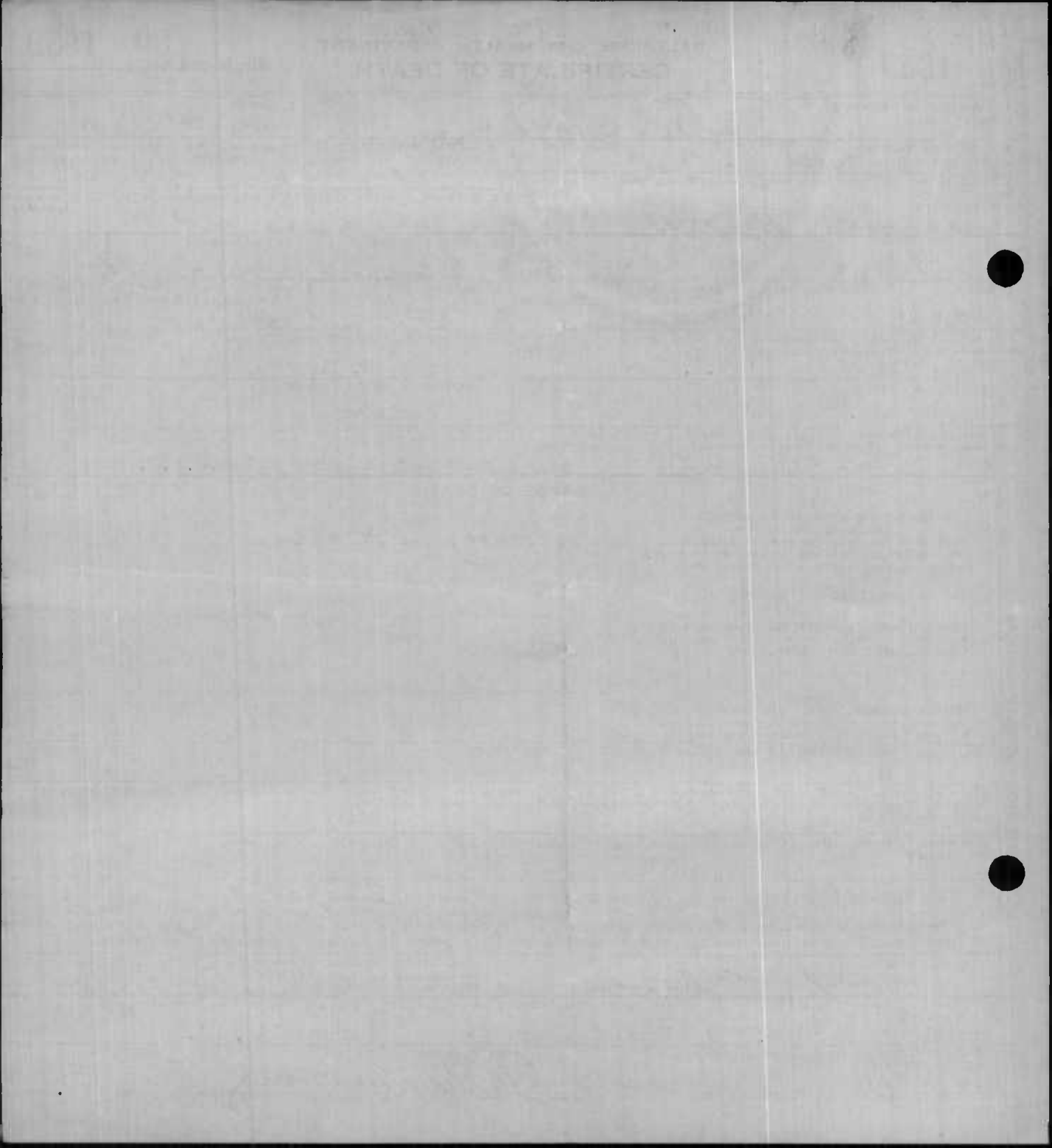
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>P. J. Lubinski</i>	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED <i>3/5/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>March 8, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Naval Cemetery</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 6 - 1950</i>	REGISTRAR'S SIGNATURE <i>William M. Williams</i>	24D. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>
FUNERAL DIRECTOR <i>Willis Lamoreaux</i>		ADDRESS <i>4510 Liberty Heights Ave.</i>

112 96

94a ✓



624
50 1960

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1960
3/2/50

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Emma Marcell

2. DATE
OF
DEATH

3/2/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore City

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

420 N. Exeter St

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

420 N. Exeter St
Baltimore City

D. STREET ADDRESS (If rural, give location)

420 N. Exeter St

C. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

March 10

9. AGE (In years;
last birthday)

71

10. Under 1 Year
Months; Days

11. Under 24 Hours
Hours; Min.

10A. USUAL OCCUPATION (Give kind of
work during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Harford Co Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Elijah Bond

14. MOTHER'S MAIDEN NAME

Wilkey

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Esther Jackson Edmonson

1615 ADDRESS

18. 446X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Nephrosis

INTERVAL BETWEEN
ONSET AND DEATH

5 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

Arteriosclerosis

4 yrs

II

(C)

Senile changes

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

22. I hereby certify that I attended the deceased from Jan 3, 1948, to Feb 2, 1950, that I last saw the deceased alive on Feb 2, 1950, and that death occurred at 9:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

A. C. Surwef

M. D.

23B. ADDRESS

171 Ridgely St

23C. DATE SIGNED

3-3-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

March 6 1950

24C. NAME OF CEMETERY OR CREMATORY

St. Calvary Cemetery

24D. LOCATION (City, town, or county)

Baltimore City

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams

25. FUNERAL DIRECTOR

Robert Williams

ADDRESS

1575 McElroy

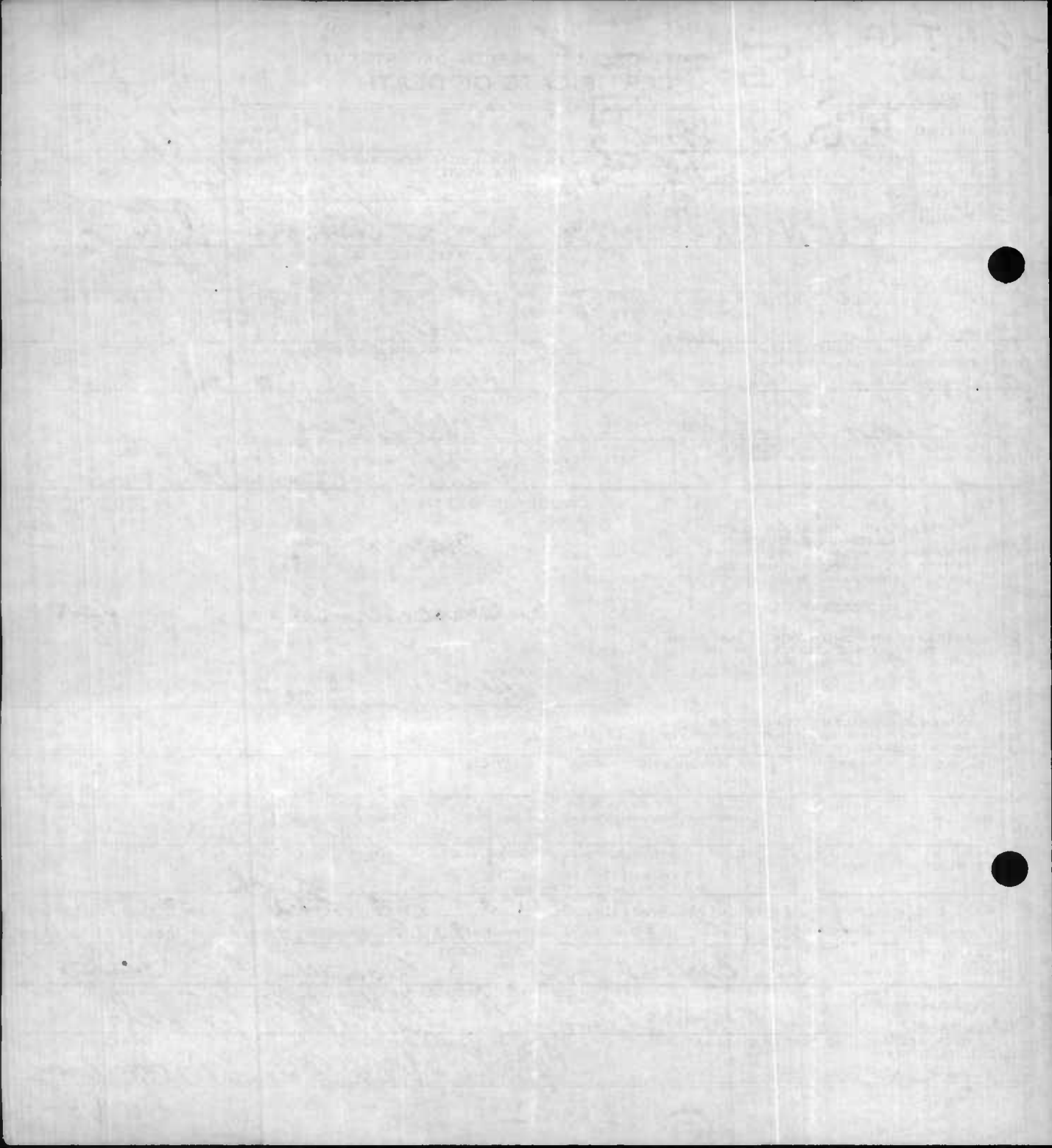
MAR 6 - 1950

VS 150

97

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1961

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEWIS

MILBURN

2. DATE
OF
DEATH

February 28, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1401 Born Court

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

6/8/195

9. AGE (In years
last birthday)

6-9

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR
INDUSTRY

CONTRACTOR

11. BIRTHPLACE (State or foreign country)

ST. MARYS Co., MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WORLD WAR I

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ELIZABETH SMITH, 25 N. BRUCE ST

18. 4221

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular
disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....23C. DATE SIGNED
2-1-5024A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

3/6/50

Baltimore National

Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

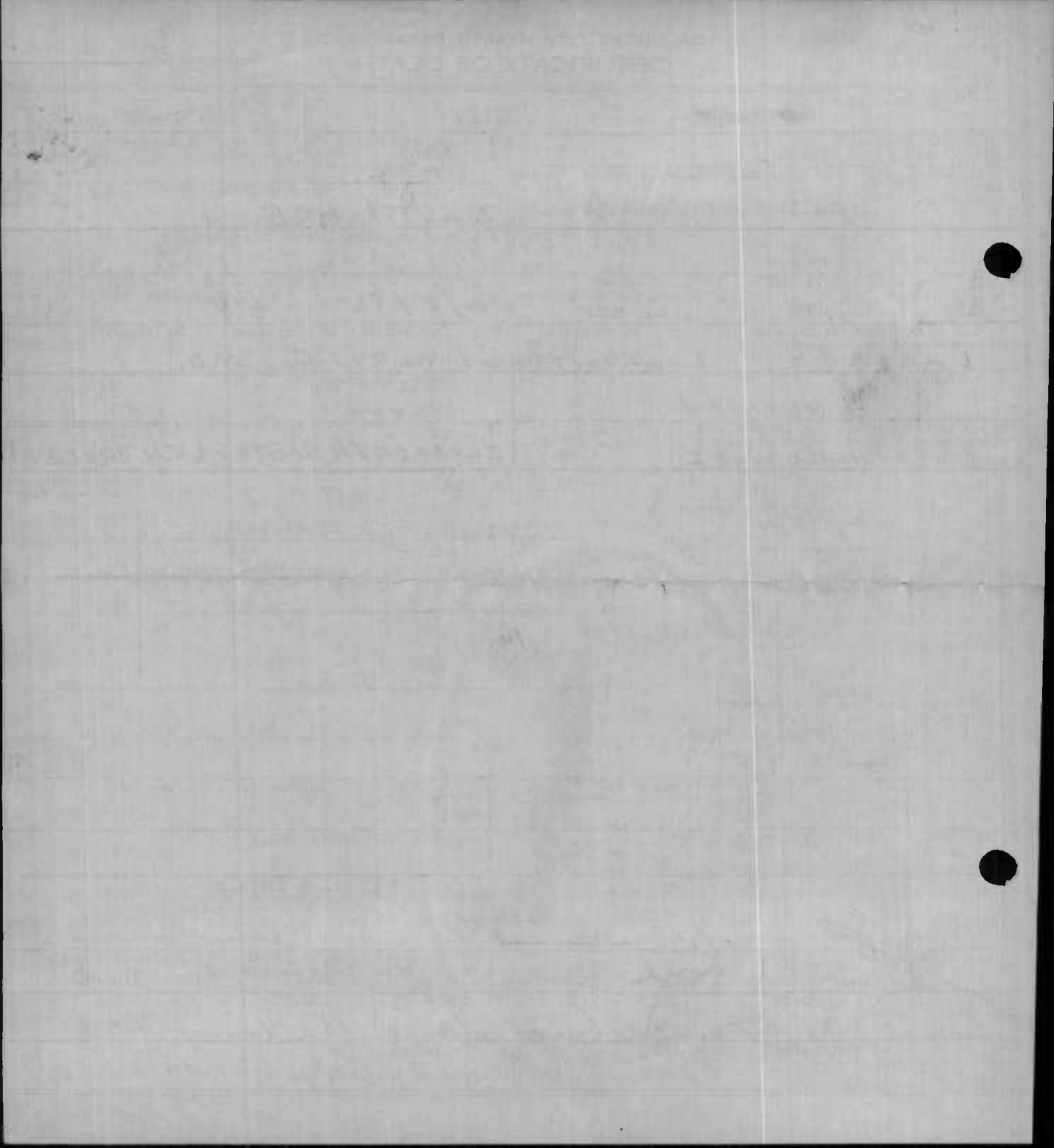
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6-1950

Joseph A. Sincely 661 W. Barge St.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1962
Registered No.

50 1962
BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

John Francis Burns

2. DATE
OF
DEATH

3/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

5709 Belair Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. STREET ADDRESS (If rural, give location)

5709 Belair Road

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

May 3-1894

9. AGE (In years
last birthday)

55

If Under 1 Year
Months: Days

If Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Belair Hotel Houseman

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY

13. FATHER'S NAME

Henry Burns

14. MOTHER'S MAIDEN NAME

Mary Elizabeth Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Helen Burns 5709 Belair

18. *491X*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

*Mar 1 to Mar 4/50
Bronchitis*

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

None

None

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *Mar 2-1950*, to *Mar 4*, 1950, that I last saw the deceased alive on *Mar 4*, 1950, and that death occurred at *3-30 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

W. Kelly

23B. ADDRESS

100 N Linwood Ave

23C. DATE SIGNED

Mar 5/50

24A. BURIAL, CREMA-
TION REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

3/7/50

New Cathedral

Balto Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6-1950

William Williams

Leonard J. Luck 5305 Harford

Dr. Kelly
100 N. Lakewood

540

50 1963

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1963

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)EDGAR
Albert Hammel2. DATE
OF
DEATH

3/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Maryland General Hospital

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct 25, 1926

9. AGE, in years
last birthday

63

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of work life, even if retired)

Pharmacist

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore - Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jacob B. Hammel

14. MOTHER'S MAIDEN NAME

Mary Hook -

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

819-2813810

17. INFORMANT

Anna Hammel

ADDRESS

Soma -

18. 332X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Pulmonary infection

DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

20 minutes

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

Cerebral thrombosis

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/25/50, 1950, to 3/4, 1950, that I last saw the
deceased alive on 3/4, 1950, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

Leonard J. Luck

Leonard J. Luck - 5305 Mayford Rd

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324
Dr. Harding
50 1964BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1964
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Arthur Lee Hetzler

2. DATE
OF
DEATH

Mar. 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)

5134 Belair Road

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5134 Belair Road

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Mar. 7, 1893

9. AGE (in years
last birthday)

56

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Self-Employed

10B. KIND OF BUSINESS OR
INDUSTRY

Confectionery Store

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Hetzler

14. MOTHER'S MAIDEN NAME

Mary Michael

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Frances G. Hetzler, 5134 Belair

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Acute Cardiac Dilatation

4 days

DUE TO

ANTECEDENT CAUSES

(B)

Myocarditis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

Coronary Disease

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/21, 1950, to March 4, 1950, that I last saw the
deceased alive on March 3, 1950, and that death occurred at 9a. m., from the causes and on the date stated above.

23A. SIGNATURE

J. S. Harding

M. D.

23B. ADDRESS

3805 Belair Rd

23C. DATE SIGNED

3/4/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3-7-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

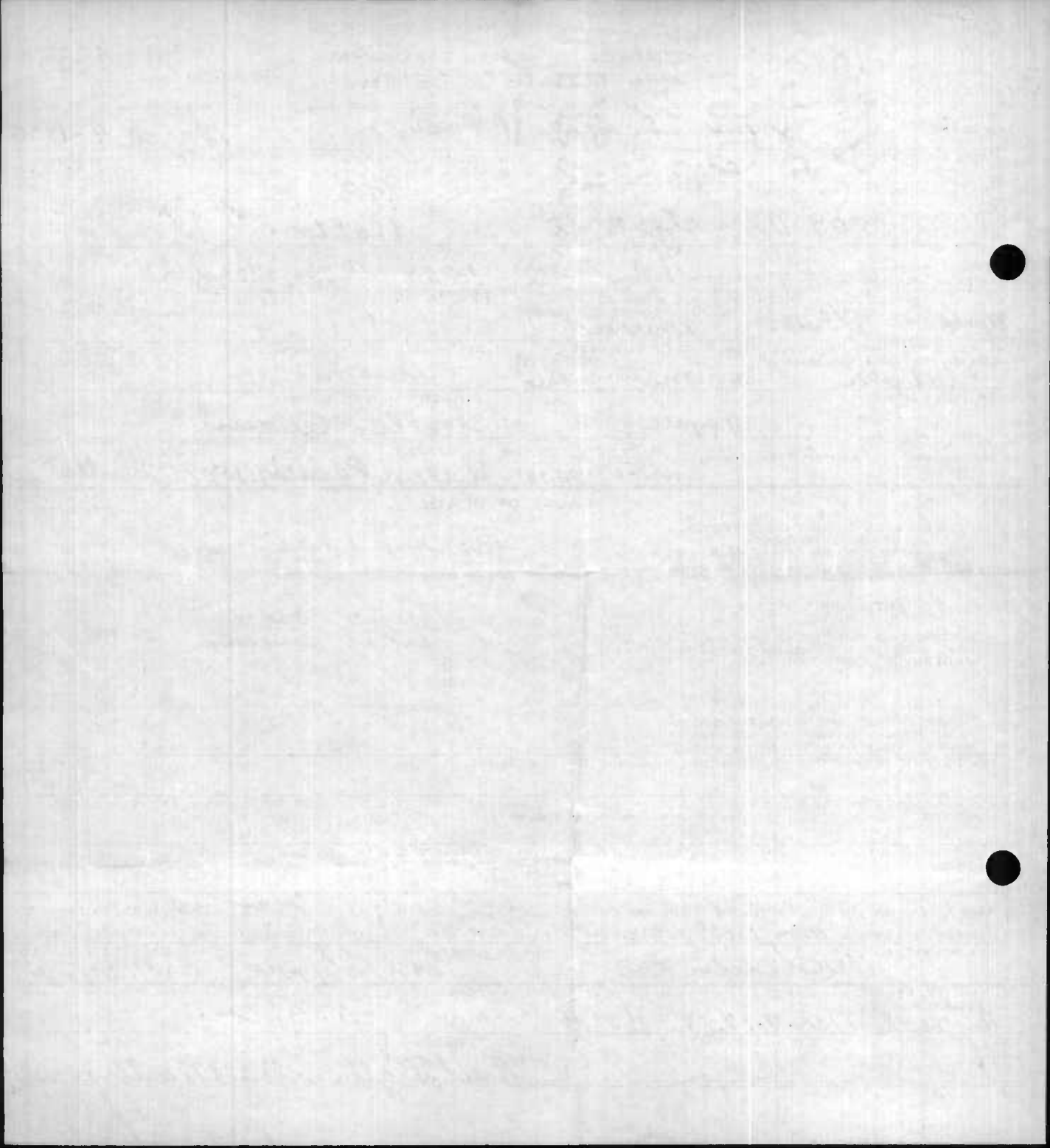
ADDRESS

Leonard J. Ruck, 5305 Harford Road.

W. J. ...
...
...

...
...
...

BIRTH NO.		1. NAME OF DECEASED (Type or Print) John Papiesz (Papiz)		2. DATE OF DEATH March 4-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland City		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write R.U.M.L. and give township) Balto. 25-05	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1509 Olmstead St		D. STREET ADDRESS (If rural, give location) 1509 Olmstead St.		C. Length of stay in Baltimore 40 Yrs. Mos. Days	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1885-	9. AGE (In years, last birthday) 64	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Davison Chemicals		11. BIRTHPLACE (State or foreign country) Ukrania	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Papiesz		14. MOTHER'S MAIDEN NAME Stella Cewuliska	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-07-0070		17. INFORMANT ADDRESS Helen Papiesz 1509 Olmstead St.	
18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) coronary occlusion DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. hypertensive cordis DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. vascular disease		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan , 19 49 , to Mar , 19 50 , that I last saw the deceased alive on Mar 4, 1950 , and that death occurred at 9a m., from the causes and on the date stated above.					
23A. SIGNATURE W. J. Fenton MD		M. D.		23B. ADDRESS 302 Baltimore	
23C. DATE SIGNED Mar. 6. 50		24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Mar. 7-1950	
24C. NAME OF CEMETERY OR CREMATORY Holy Cross		24D. LOCATION (City, town, or county) A. A. Co.		(State)	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		REGISTRAR'S SIGNATURE W. J. Fenton MD		25. FUNERAL DIRECTOR ADDRESS Wm. S. Fialkowski 2007 Eastern Ave	



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#300
50 1966

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1966

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MORRIS MOODY		2. DATE OF DEATH March 2, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-01	
B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN (If outside corporate limits write RURAL and give township) Baltimore	
Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 931 Saratoga Street	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
			9. AGE (in years last birthday) 79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. Marys Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George L. Walker		ADDRESS 931 W. Saratoga St	

18. **450-0**

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Arterio-sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE **Emil H. Boyer** M.D. 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED **March 2, 1950**

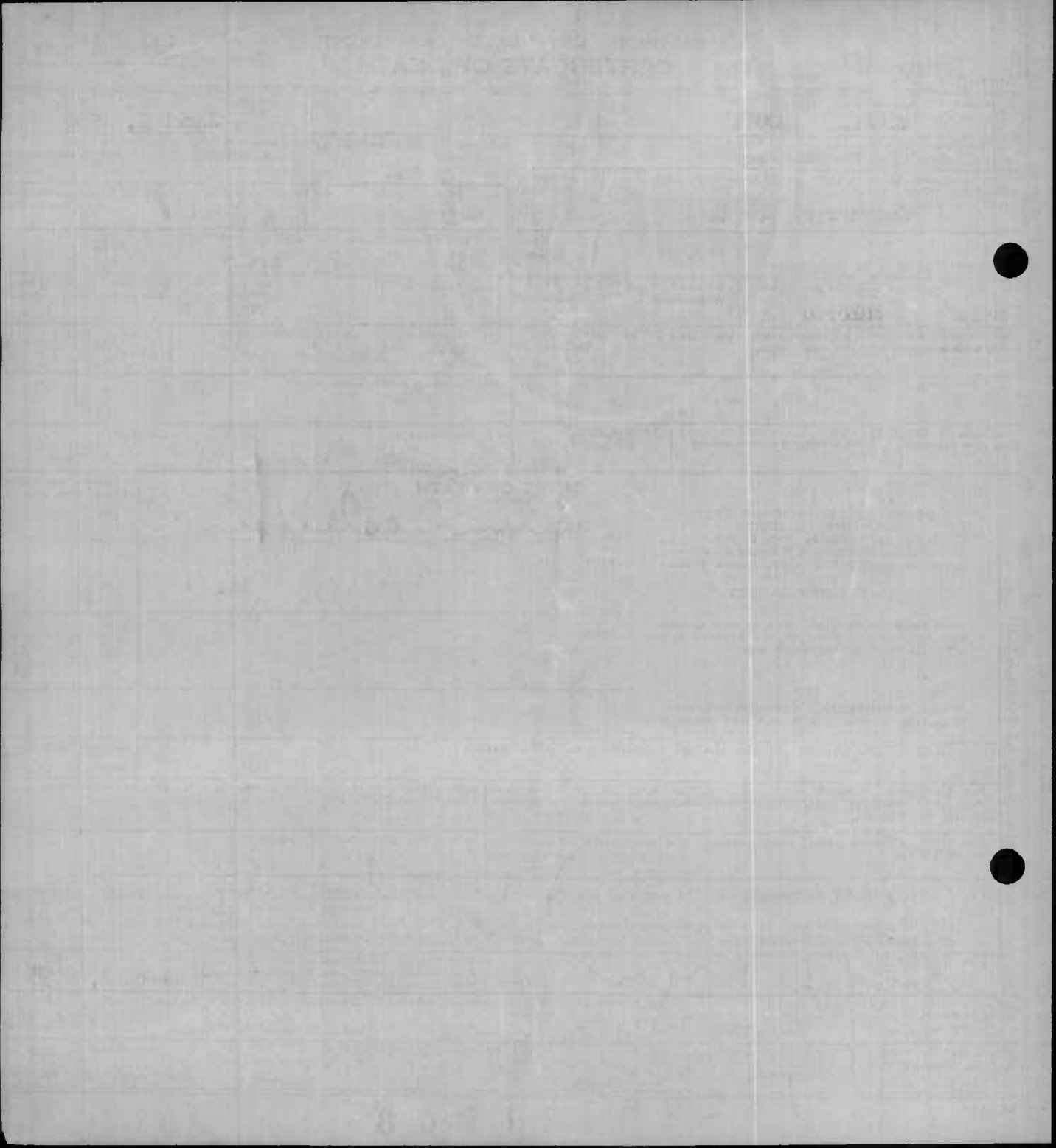
24A. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24B. DATE **3/6/50** 24C. NAME OF CEMETERY OR CREMATORY **Mt. Zion** 24D. LOCATION (City, town, or county) (State) **Baltimore, Md**

DATE RECEIVED BY LOCAL REGISTRAR **MAR 6 - 1950** REGISTRAR'S SIGNATURE **Thos. J. Williams** 25. FUNERAL DIRECTOR **Mrs. Katie R. Williams** ADDRESS **322 N. Schroeder St.**

VS 151

500001968

97 ✓



-120
50 1967

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1967

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Edmond Epps.

2. DATE
OF DEATH

March 2, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR location)
INSTITUTION

1835 Vine St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Maryland.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

20-01

D. STREET ADDRESS (If rural, give location)

1835 Vine St.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Sept. 2-1884

9. AGE (In years
last birthday)

67

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

porter

10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wilmington, Del.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Epps, Sr.

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Eora Epps. 1835-Vine St.

18. 4920

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Myocardial Failure

INTERVAL BETWEEN
ONSET AND DEATH

Feb. 23, 1950

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Virus Pneumonia

Feb. 23, 1950

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

none

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from Feb. 7, 1948, to 3-2-1950, that I last saw the
deceased alive on 3-2-1950, and that death occurred at 8 P. M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

54 S. Fulton Ave

23C. DATE SIGNED

3-5-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial
DATE RECEIVED BY
LOCAL REGISTRAR

Mar 6, 1950
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Mrs. Kate R. Williams
Schwede

VS 150

1050
1050 50 350 969

109a

MEDICAL CERTIFICATION

521
50 1968
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1968

1. NAME OF DECEASED (Type or Print) Mary Zinsavage			2. DATE OF DEATH Mar 3-1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 1338 Sargent St			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ind B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-01		
c. Length of stay in Baltimore 8 yrs			D. STREET ADDRESS (If rural, give location) 1338 Sargent St		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Oct 30-1886		9. AGE (In years last birthday) 63
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lithuanian		12. CITIZEN OF WHAT COUNTRY? no
13. FATHER'S NAME Pazarella		14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Anthony Zinsavage	
				ADDRESS 1338 Sargent	

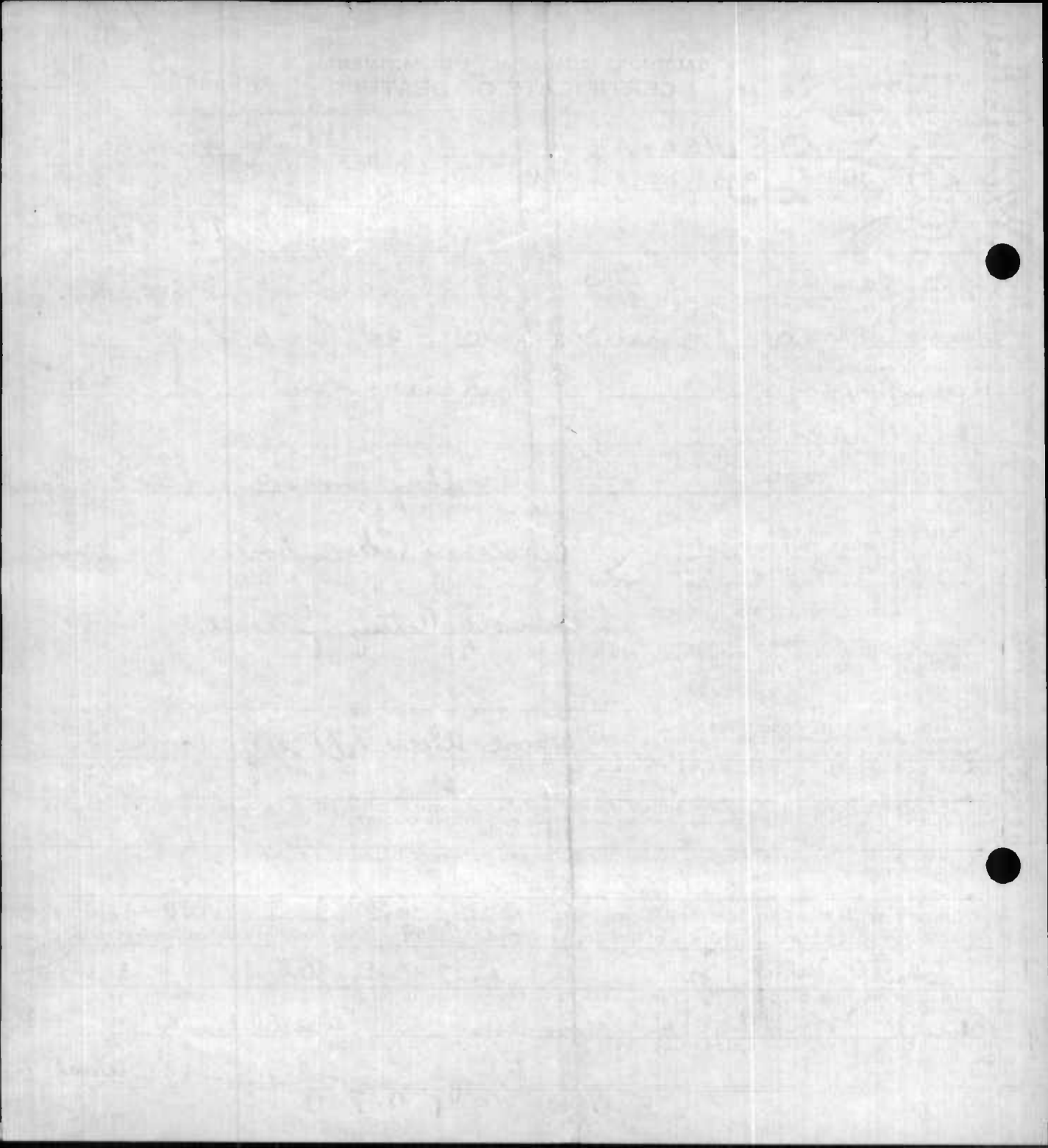
MEDICAL CERTIFICATION	18. 4/20.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
	ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Coronary Artery Disease		?
	OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Variance Ulcer left leg		?

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **3-2**, 19**50** to **3-3**, 19**50**, that I last saw the deceased alive on **3-2**, 19**50**, and that death occurred at **9:30 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE John P. Unruh, Jr		23B. ADDRESS 1227 Wash. Bldg		23C. DATE SIGNED 3-3-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE March 7-50		24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.	
24D. LOCATION (City, town, or county) (State) Anundel County Ind		25. FUNERAL DIRECTOR Joseph Kasinski		ADDRESS 602 Wash. Bldg	

MAR 6-1950
VS 150
19500001970
94a



correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1969
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Amelia A. Stroman (Amelia A. Strofer) 3/4/50

2. DATE
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION

University Hosp.

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female.

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Sept. 27 - 1878

9. AGE (in years
last birthday)

71

10. Under 1 Year
Months: Days

11. Under 24 Hours
Hours: Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR
INDUSTRY

Metal Products

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
U.S.A. COUNTRY?

U.S.A.

13. FATHER'S NAME

Emeron M. Seidel

14. MOTHER'S MAIDEN NAME

Amelia A. Wolf

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

213-12-3190

17. INFORMANT

ADDRESS

Mr. Walter T. Seidel-6222 Fairdel Ave. Balto: Md.

18. *443X*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Hypertension C.V.D. &

48 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

secondary massive intra-

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

cerebral hemorrhage - E. g. equally
subarachnoid hemorrhage.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22. I hereby certify that I attended the deceased from *12 Mar 3/4, 1950*, to *2 pm 3/4/50*, that I last saw the
deceased alive on *3/4*, 19 *50*, and that death occurred at *2 pm*, from the causes and on the date stated above.

23A. SIGNATURE

B. A. Abraham, M.D.

23B. ADDRESS

University Hosp.

23C. DATE SIGNED

3/4/50.

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/7/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

24D. LOCATION (City, town, or county)

Edmondson Avenue

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

George J. Ruth, Inc.-1735 Harford Avenue

MAR 6 - 1950

VS 150

1950022633971

937

9/27/78 - 71

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1970

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALEXANDER GORDON

2. DATE
OF
DEATH

3-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

Doctors Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

14-01

D. STREET ADDRESS (If rural, give location)

1617 Eutaw Place

Length of stay in Baltimore 20 YEARS

Yrs.
Mos.
Days

5. SEX

MALE

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

July 30, 1891

9. AGE (In years
last birthday)

58

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

purchasing agt.

10B. KIND OF BUSINESS OR
INDUSTRY

oil

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF
WHAT COUNTRY?

U.S. F. -

13. FATHER'S NAME

John Gordon

14. MOTHER'S MAIDEN NAME

Elizabeth McLean

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.
213-05-3946

17. INFORMANT

Mrs. Stowey Gordon

ADDRESS

1617 Eutaw Place

18. 332X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Cerebral thrombosis

DUE TO

1 day

I. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Diabetes mellitus

2 years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/4/50, 19, to 3/5/50, 19, that I last saw the
deceased alive on 3/5/50, 19, and that death occurred at 1:55 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Mam. Friedman

M. D.

23B. ADDRESS

1737 E. North Avenue

23C. DATE SIGNED

3/5/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/8/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

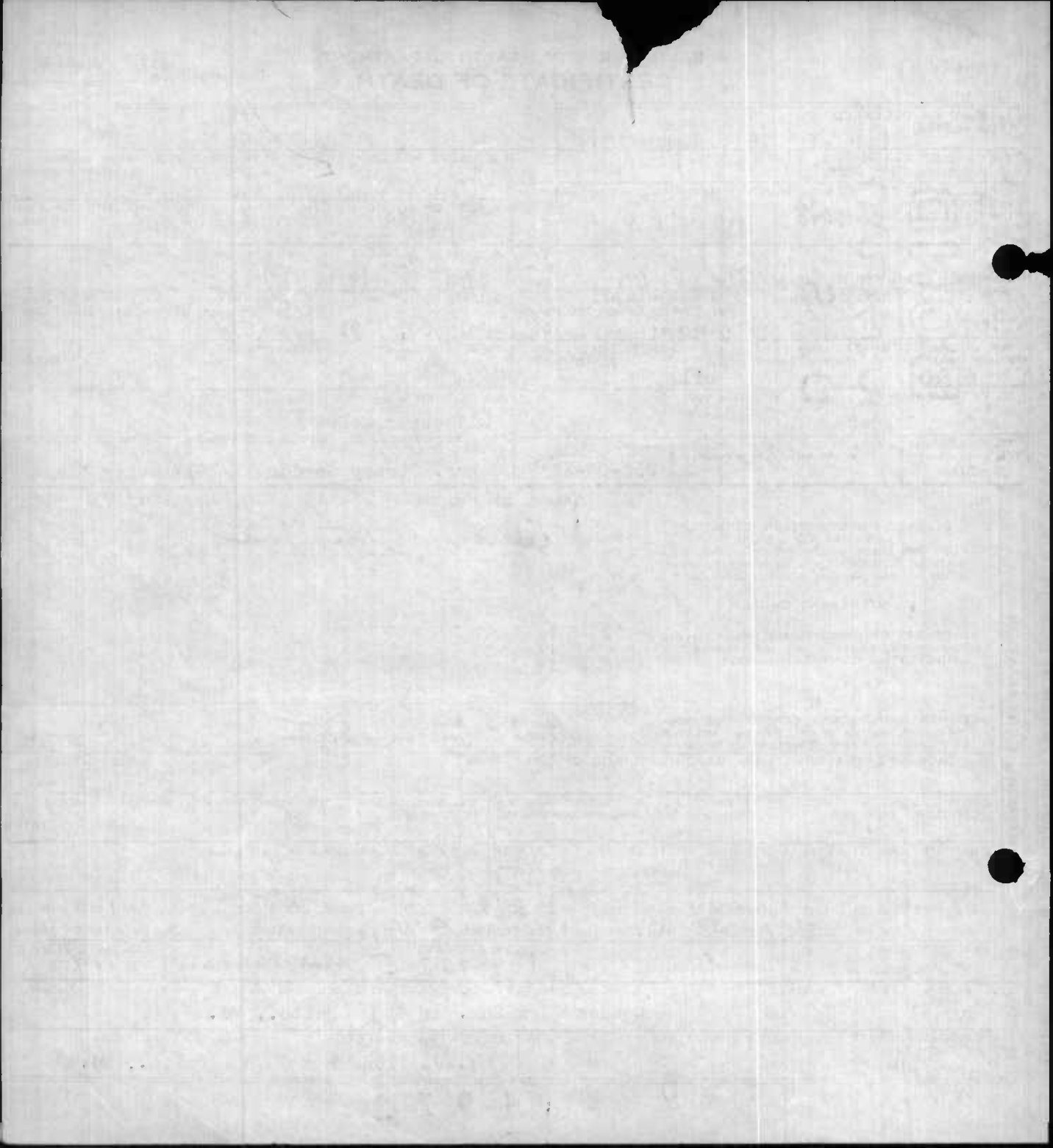
WM. J. TICKNER & SONS

Balto., Md.

VS 150

136V4972

61



623
50 1971BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1971
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Edw. Wright

2. DATE
OF
DEATH

March 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION Johns Hopkins Hospital4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Cockeysville (Rural)

D. STREET ADDRESS (If rural, give location)

Beaverdam Road

Length of stay in Baltimore

8 days

5. SEX

M

6. COLOR OR RACE

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Dec. 24, 1926

9. AGE (In years
last birthday)

23

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR
INDUSTRY

County Roads

11. BIRTHPLACE (State or foreign country)

Balto Co., Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harvey Wright

14. MOTHER'S MAIDEN NAME

Jilly Swann

15. WAS DECEASED EVER IN U. S. ARMED FORCES
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Harvey Wright, Cockeysville, Md

18. E812.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

Fat Embolism
Multiple fractures of spine
& ribcage

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Beaverdam Rd., Cockeysville, Md. 5300

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

Feb. 26, 1950 ab't. noon

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto (hit & run)

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Earl H. Royer

23B. CHIEF MEDICAL EXAMINER.....
ASSISTANT MEDICAL EXAMINER.....
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

March 6, 1950

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

Mar. 7, 1950

24C. NAME OF CEMETERY OR CREMATORY

Basil

24D. LOCATION (City, town, or county) (State)

Cockeysville, Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

Landon M. Brooks, Sparks, Md

VS 151

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170C

CERTIFICATE OF DEATH

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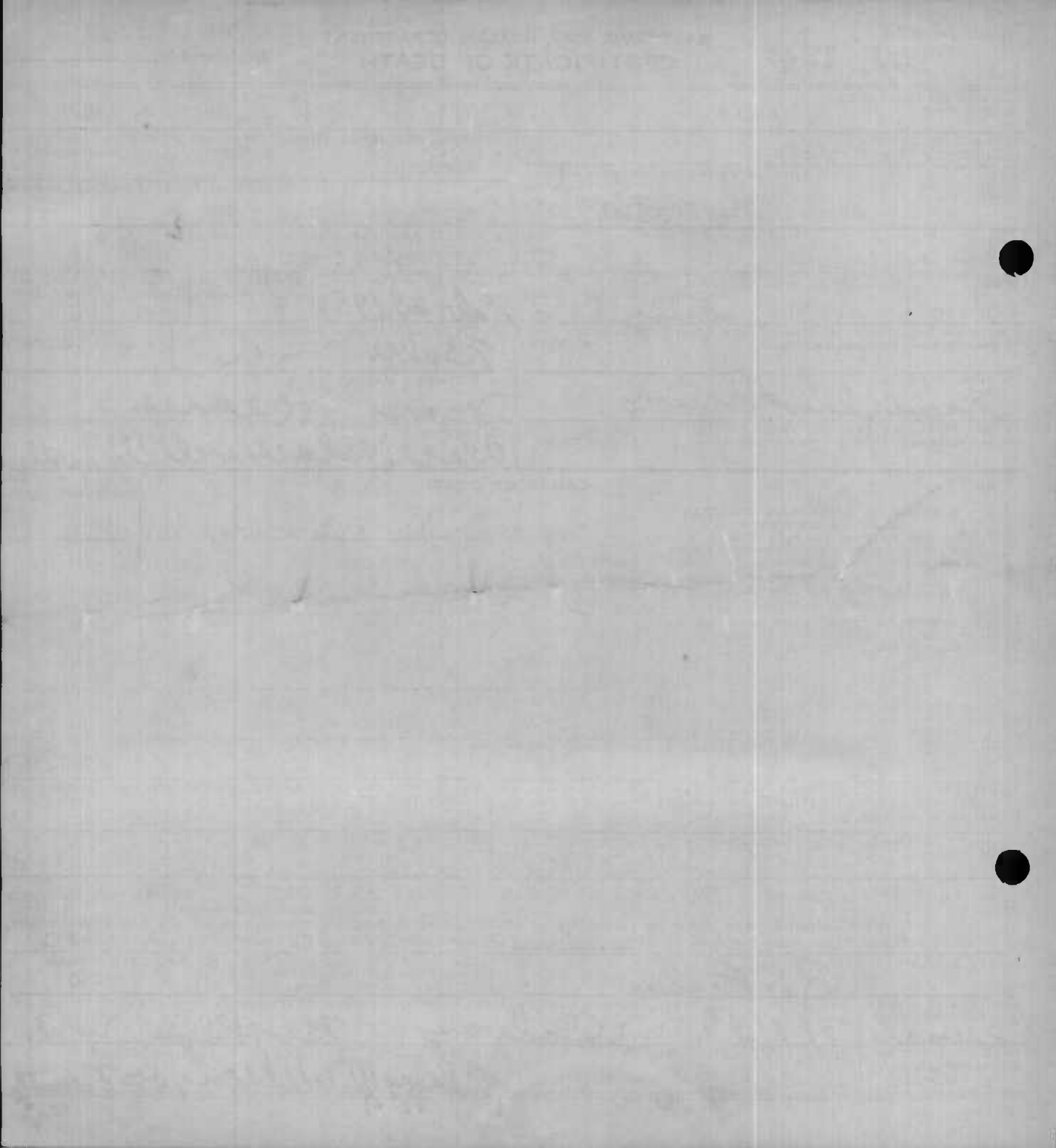
**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1972
Registered No. _____

120
50 1972
BIRTH NO. 50-23777

1. NAME OF DECEASED (Type or Print) ALICE DAVIS		2. DATE OF DEATH March 4, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Maryland b. COUNTY _____	
b. FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		d. STREET ADDRESS (If rural, give location) 1210 Nolan Court	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Feb 25, 1950
9. AGE (In years last birthday) 7		10. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Balto Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Franklin Davis		14. MOTHER'S MAIDEN NAME Mary Reares	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Alice Blackwell		ADDRESS 1212 Fayette	

18. 771.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hemorrhagic disease of newborn DUE TO		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19a. DATE OF OPERATION		
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23a. SIGNATURE R S Fisher		23b. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> M.D.
23c. DATE SIGNED 3-4-50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/7/50	24c. NAME OF CEMETERY OR CREMATORY Int Calvary
24d. LOCATION (City, town, or county) (State) Brooklyn Md	24e. FUNERAL DIRECTOR Shroy Wilson	
24f. ADDRESS 1000 Bland		



I-526

50 1973

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1973

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM L. INGRAM

2. DATE
OF
DEATH

3/4/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD.

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

126 W. LEE ST.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

22-01

D. STREET ADDRESS (If rural, give location)

126 W. LEE ST 22-01

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

SINGLE

8. DATE OF BIRTH

FEB 24, 1873

9. AGE (in years;
last birthday)

27

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

CIVIL SERVICE

10B. KIND OF BUSINESS OR
INDUSTRY

GOVERNMENT

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

LOYD INGRAM

14. MOTHER'S MAIDEN NAME

SARAH SPARROW

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)16. SOCIAL
SECURITY NO.

213-12-6709

17. INFORMANT

ADDRESS

MR. JOHN INGRAM 126 W. LEE ST.

18. 443 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardio vascular
disease.

?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) General and arterio sclerosis

?

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (o. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ HOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from Feb. 22, 1950 to 3/4/50, 19__, that I last saw the
deceased alive on 3/3/ 1950. and that death occurred at 7:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Harry Deibel

M. D.

1226 Hanover Street,

3/6/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

JOHN F. DENNY, INC 715 LIGHT ST -30

VS 150

1 9 5 0 0 0 0 1 9 7 5

937

MEDICAL CERTIFICATION

St. Michael

166
50 1974BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1974
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Wilhelmina P. Everhardt</i>		2. DATE OF DEATH <i>Mar 6 - 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1925 Hampalds Ave</i>		4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>25-03 B</i>	
5. Length of stay in Baltimore <i>58 1/25</i>		D. STREET ADDRESS (If rural, give location) <i>1925 Hampalds Ave.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Feb. 1 - 1895</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years: last birthday) <i>75</i>
13. FATHER'S NAME <i>William H. Steinmann</i>		11. BIRTHPLACE (State or foreign country) <i>Selmon Kentucky</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Amelia Wilcox</i>	
17. INFORMANT <i>Bennie L. Hearn</i>		ADDRESS <i>1925 Hampalds Ave</i>	

18. <i>4/20/1</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		<i>Immediate</i>
(A) <i>Coronary thrombosis</i> DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(B) <i>Hypertensive cardiac vascular disease.</i> DUE TO		<i>About 4 years.</i>
(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/30/46*, 19*46* to *3/6/50*, 19*50*, that I last saw the deceased alive on *3/5/50*, and that death occurred at *12 mid-nite* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Harry Deile</i>	23B. ADDRESS <i>1226 Hanover Street,</i>	23C. DATE SIGNED <i>3/6/50</i>
-----------------------------------	--	--------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>March 10, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Hollywood Mem Richmond Va</i>	24D. LOCATION (City, town, or county) (State) <i>Richmond Va</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>MAR 6 - 1950</i>	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR <i>John C. Wilby</i>	ADDRESS <i>2435 E Olney St</i>

[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

516
50 1975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1975
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILBERT U. AMBROSE SR.

2. DATE
OF
DEATH

March 4, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

825 Union Ave.

C. CITY OR TOWN

Balt.

13-07

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

825 Union Ave.

c. Length of stay in Baltimore

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb 9, 1882

9. AGE (In years: last birthday)

68

10. Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer, District

10B. KIND OF BUSINESS OR INDUSTRY

City Water Dept.

11. BIRTHPLACE (State or foreign country)

md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Margaret H. Ambrose, 825 Union Ave.

18. 331X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary Hemorrhage 2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour) OF INJURY

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 3, 1950, to March 4, 1950, that I last saw the deceased alive on March 3, 1950, and that death occurred at 10:10 PM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

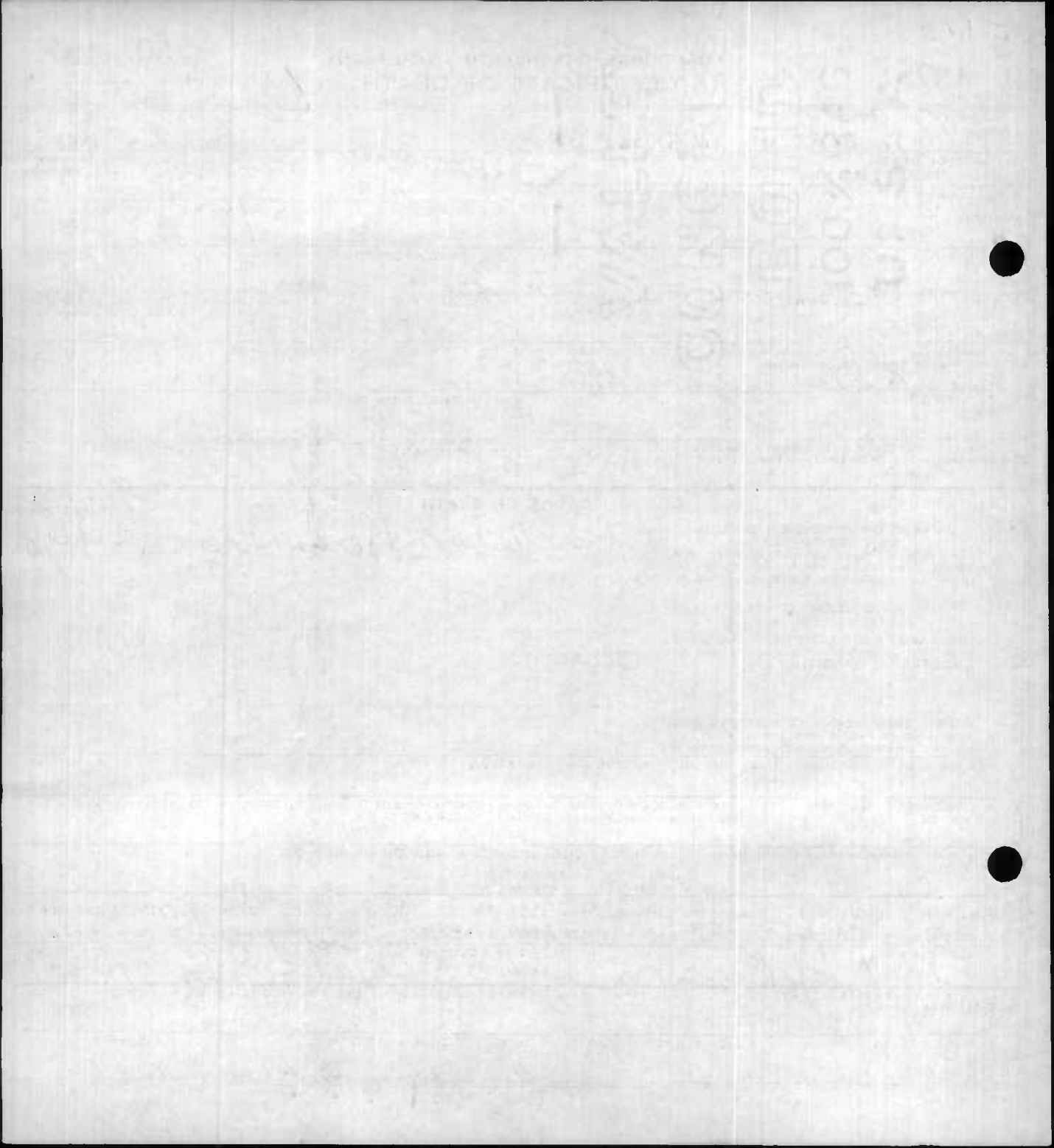
ADDRESS

MAR 6 - 1950

Paul E. Johnson

Paul E. Johnson

65-17 Liberty Ave.



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

50 1976
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT HOMER FULLER		2. DATE OF DEATH 3/5/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSP.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-07	
D. STREET ADDRESS (If rural, give location) 1722 Montpelier St.		E. Length of stay in Baltimore Yrs. Mos. Days	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 28th 1976
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Foreman		10B. KIND OF BUSINESS OR INDUSTRY B.T. Co.	
13. FATHER'S NAME Wm. H. Fuller		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		ADDRESS	

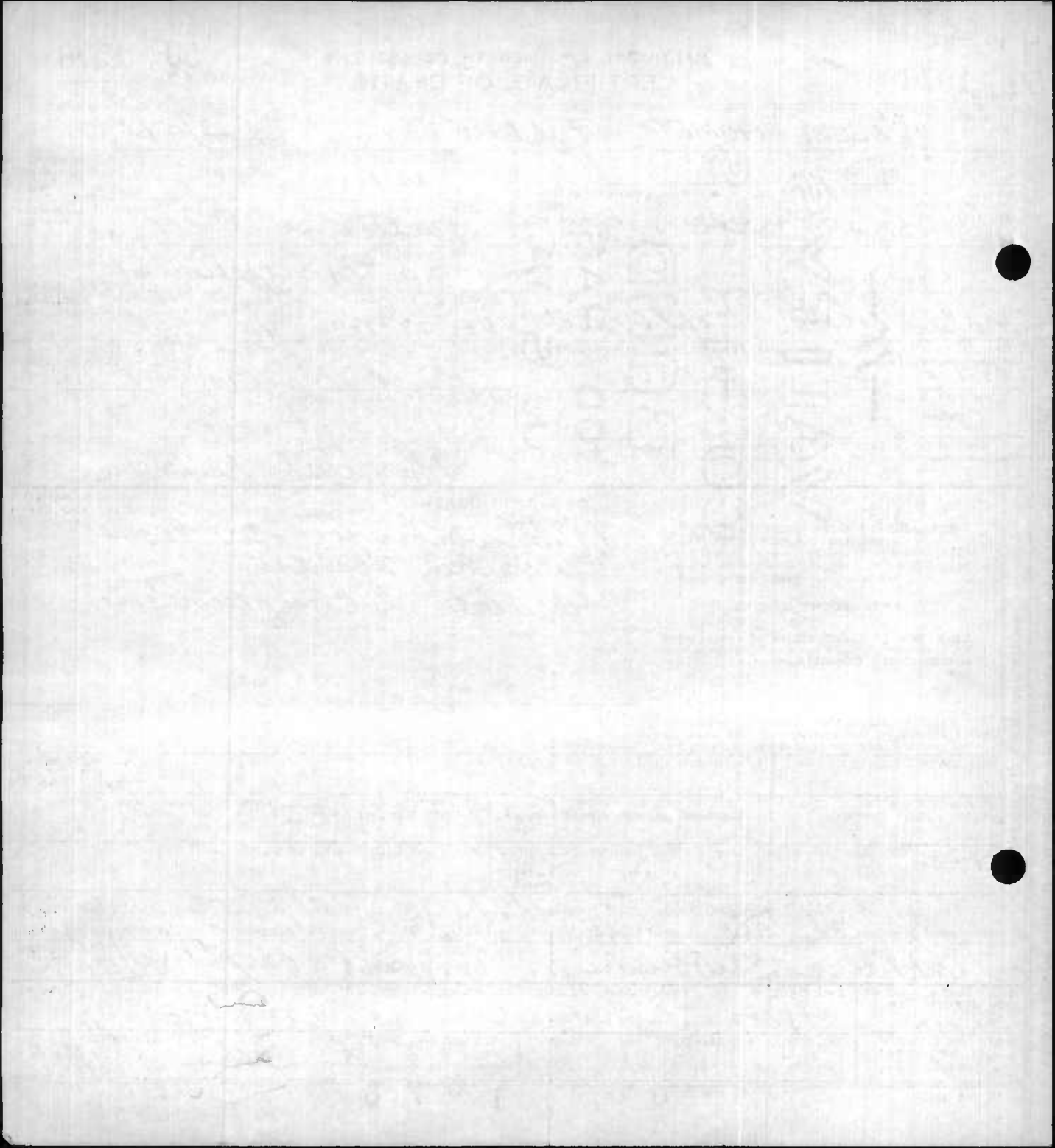
MEDICAL CERTIFICATION

18. 472.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH Arteriosclerotic cardio-vascular disease DUE TO Cardiac decompensation DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/9/50 , 19__, to 3/5/50 , that I last saw the deceased alive on 3/5/50 , and that death occurred at 12:30 m., from the causes and on the date stated above.					
23A. SIGNATURE Madeline Swinski M. D.		23B. ADDRESS St. Joseph's Hosp.		23C. DATE SIGNED 3/5/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/8/50		24C. NAME OF CEMETERY OR CREMATORY Parlwood Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25. FUNERAL DIRECTOR Lorraine Funeral Home		ADDRESS 7401/36 Ave 17d.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		REGISTRAR'S SIGNATURE James J. [illegible]		VS 150	

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655
50 1977

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1977
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SUE ELIZABETH HERRMAN		2. DATE OF DEATH MARCH 4, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSP.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 7902 Belair Rd.			
5. SEX Female		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH OCT. 28th 1896	
9. AGE (In years last birthday) 53		10. UNDER 1 Year Months: Days	
11. UNDER 24 Hours Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10B. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Balto. Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chas. H. Davis		14. MOTHER'S MAIDEN NAME Josephine Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		ADDRESS	

18. 445X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Malignant hypertension, essential		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
(B) DUE TO		
(C) DUE TO		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

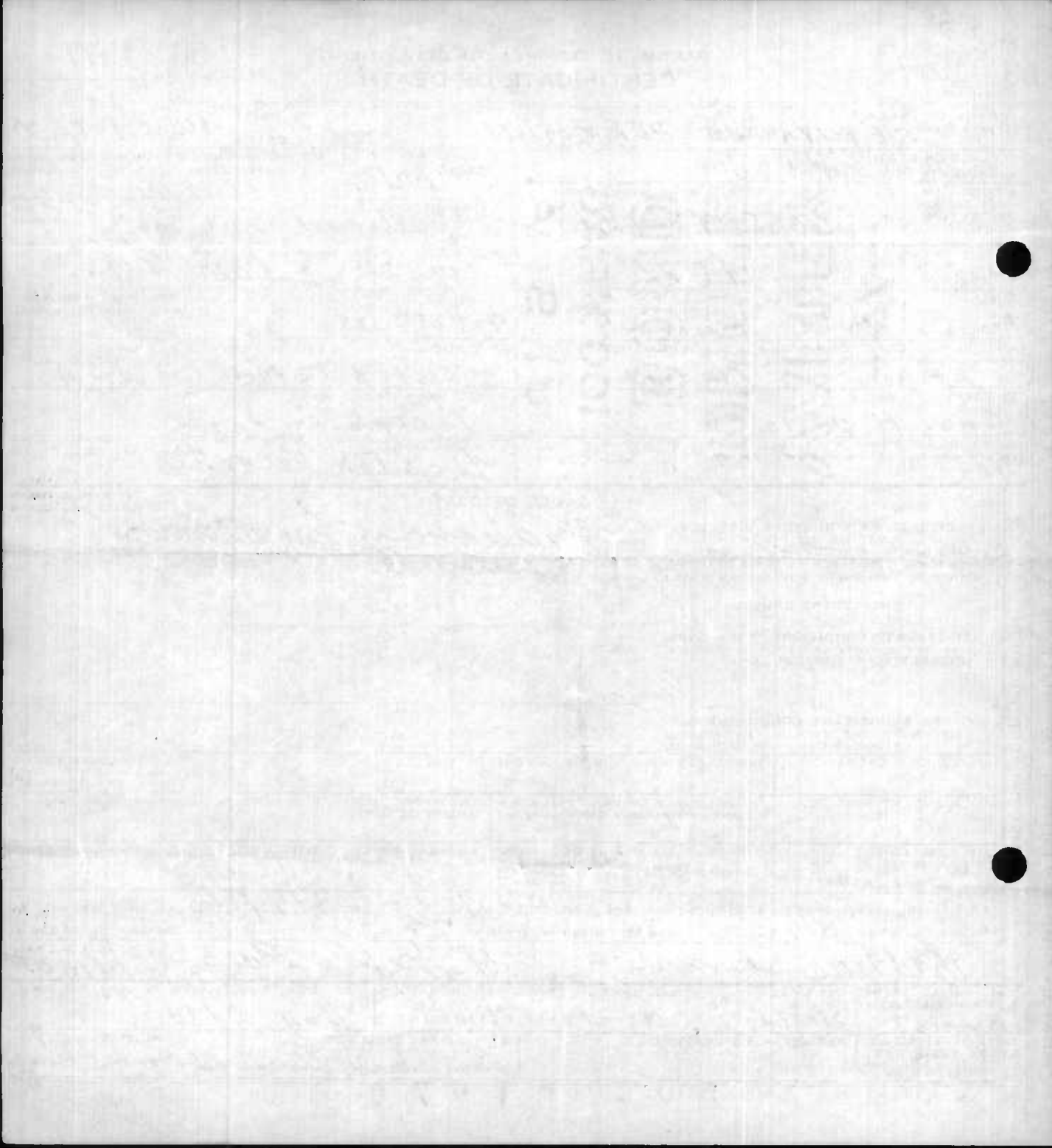
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **2/23/50**, to **3/4/50**, that I last saw the deceased alive on **3/4/50**, and that death occurred at **7:48** m., from the causes and on the date stated above.

23A. SIGNATURE Maddeus Sawinski		23B. ADDRESS St. Joseph's Hosp.		23C. DATE SIGNED 3/4/50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/8/50	24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial	24D. LOCATION (City, town, or county) (State) Balto. Md	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR Lansbury Funeral Home		
		ADDRESS 7401 Belair Rd.		

correct age is especially important. Physicians: please write the causes of death clearly and legibly

MEDICAL CERTIFICATION



200

CERTIFICATE CORRECTED 8-22-50

50 1978 135 420

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1978
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Florence V. Gauss

2. DATE
OF
DEATH

3-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street address or location)Baltimore City Hospitals
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1026 Riverside Ave. -30

C. Length of stay in Baltimore

45 yrs.

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Widow

8. DATE OF BIRTH

Dec. 7, 1878

9. AGE (In years
last birthday)

71

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME
William Finkel Finkle

14. MOTHER'S MAIDEN NAME

Margaret Woods

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT
ADDRESS
B. C. H. Records, 4940 Eastern Ave.

18. 170X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) Metastatic Carcinoma -Right Breast

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 1-31-50, 19, to March 5, 19 50 that I last saw the
deceased alive on March 5, 19 50, and that death occurred at 2.15AM., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

4940 Eastern Ave.

3-5-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

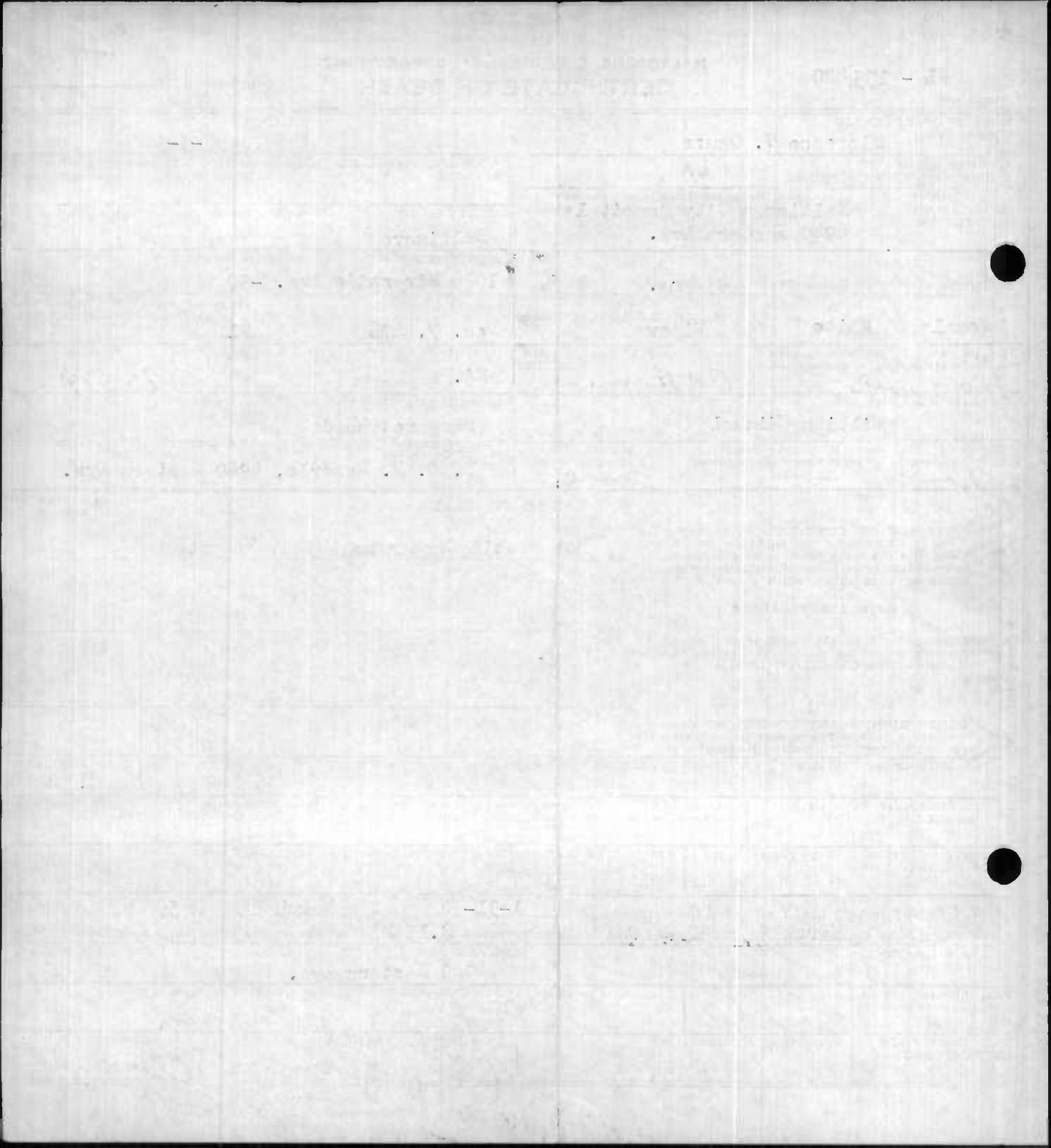
VS 150

P. Howard Evans 14005 Charles St.

Baltimore 30, Md. 50

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION



324
50 1979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 50 1979

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ridgely, Merhl M.		2. DATE OF DEATH 3/5/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore	
B. FULL NAME OF HOSPITAL OR INSTITUTION U.S. Marine Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
D. STREET ADDRESS (If rural, give location) 2813 Harlem Ave. Balto., Md.		E. LENGTH OF STAY IN BALTIMORE unk	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1/31/97
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk Unknown		10B. KIND OF BUSINESS OR INDUSTRY Naval Brd. Lab.	9. AGE (In years last birthday) 53
11. BIRTHPLACE (State or foreign country) Fredrick, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unk Charles Ridgely		14. MOTHER'S MAIDEN NAME unk Ellen Stull	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unk NO		16. SOCIAL SECURITY NO. 216-07-5041	
17. INFORMANT Records, USMH Balto., Md.		ADDRESS	
18. 410X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism with infarction (A) MICROBIAL INFECTION EXCEPT TUBERCULOSIS DUE TO Mitral and aortic stenosis with insufficiency and mural thrombus of atria, unilateral due to rheumatic heart disease. (B) Bronchopneumonia (C)		INTERVAL BETWEEN ONSET AND DEATH 1 wk. Many yr. 1 wk.	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
19A. DATE OF OPERATION none		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) none		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb 25 , 19 50 , to March 5 , 19 50 , that I last saw the deceased alive on 2-5 , 19 50 , and that death occurred at 5:50 A.m., from the causes and on the date stated above.			
23A. SIGNATURE Joseph Leighton (O.D.)		23B. ADDRESS USMH Balto., Md.	
23C. DATE SIGNED 3/5/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/8/50	
24C. NAME OF CEMETERY OR CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Woodlawn Md.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		REGISTRAR'S SIGNATURE J.T. Stansbury	
25. FUNERAL DIRECTOR J.T. Stansbury		ADDRESS 2700 Edmondson Ave.	

VS 150

V7096

92R

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

252

50 1980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1980

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Razmus

2. DATE
OF
DEATH

March 5 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR INSTITUTION

1012 S. Clinton St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

26-11

D. STREET ADDRESS (If rural, give location)

1012 S. Clinton St.

c. Length of stay in Baltimore

7 yrs

Yrs.

Mos.

Days

5. SEX

Male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Dec 26 1882

9. AGE (In years; last birthday)

67

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Joseph Razmus

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

Josephine Urban

ADDRESS

1012 S. Clinton St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A)

CORONARY OCCLUSION

3HRS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

ARTERIO SCLEROSIS GEN.

10YRS.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from Nov. 2, 1949, to March 5, 1950, that I last saw the deceased alive on March 5, 1950, and that death occurred at 10 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Benjamin Hightstein

M. D.

121 S. HILHARD AVE.

3/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

March 8 1950

Sacred Heart Cemetery

German Hill Road Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

Benjamin Hightstein

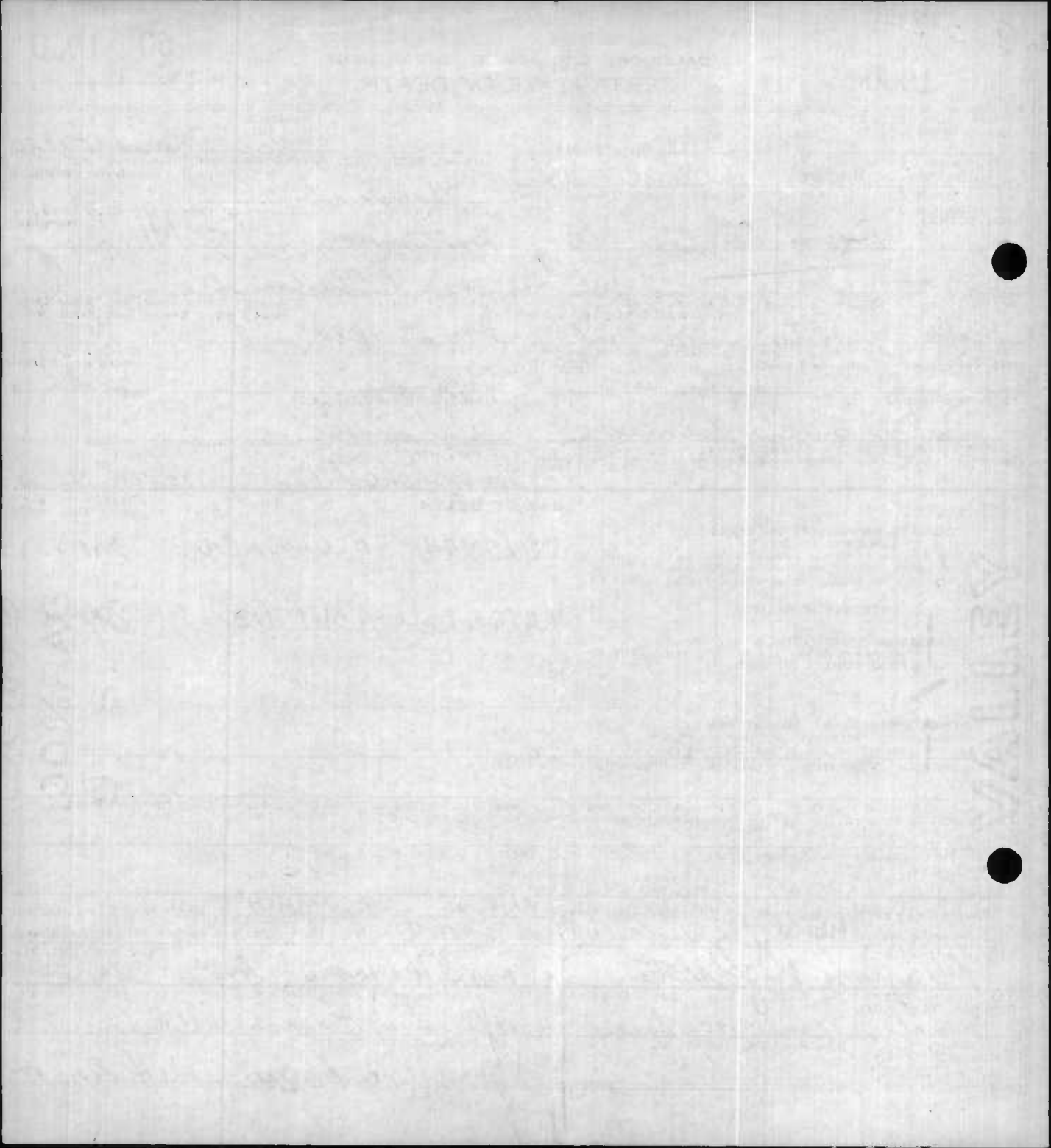
John J. Huda Inc. 2829 Hudson St.

VS 150

94499

94a

Correct age is especially important. Physicians, please give exact date of death and age at death.



-610

50 1981

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

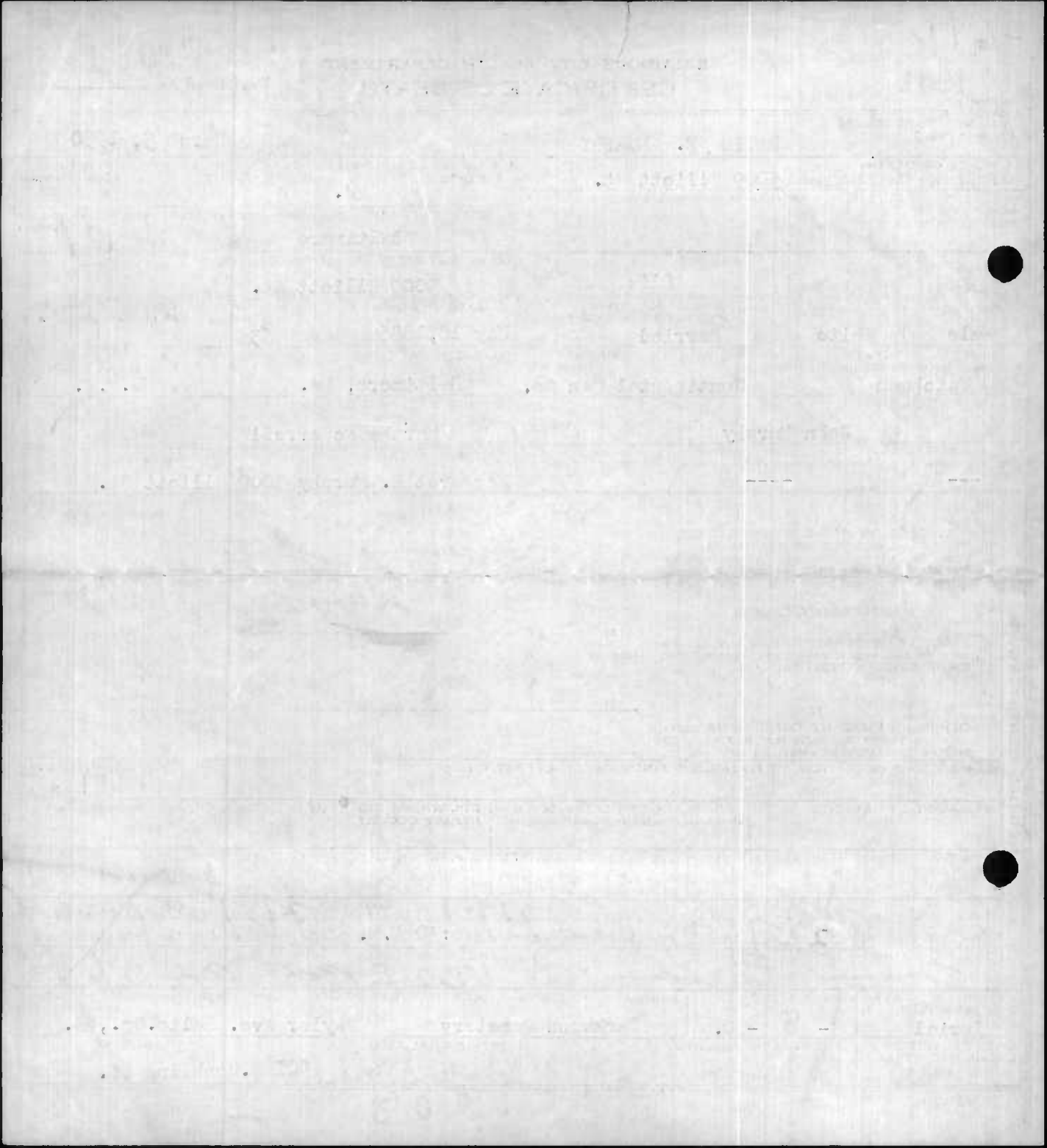
50 1981
Registered No. _____

1. NAME OF DECEASED (Type or Print) DAVID F. MURPHY			2. DATE OF DEATH March 5, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland 3009 Elliott St.			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION 60			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 3009 Elliott St.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 10, 1886	9. AGE (In years last birthday) 63	10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY Continental Can Co.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Murphy			14. MOTHER'S MAIDEN NAME Martha McFarrell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	17. INFORMANT ADDRESS Margaret E. Murphy 3009 Elliott St.		
18. 163X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the lung DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH 1 year		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7/30/1949 to 3/5/1950 , that I last saw the deceased alive on 3/5/1950 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.					
23A. SIGNATURE Dr. J. Friedman		23B. ADDRESS 1737 E. North Ave.		23C. DATE SIGNED 3/6/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-8-50.		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Taylor Ave. Balto. Co., Md.		24E. FUNERAL DIRECTOR Charles S. Seiler		24F. ADDRESS 901 S. Conkling St.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		REGISTRAR'S SIGNATURE Thompson		25. FUNERAL DIRECTOR ADDRESS 901 S. Conkling St.	

602 519 83

47D

MEDICAL CERTIFICATION



660
50 1982

1982
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1982

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Corita Cecelia Sharrer

2. DATE
OF
DEATH

March 5 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

2850 N. Charles St. Md.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2850 N. Charles St. Balto. 18, Md.

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Yrs.
Mos.
Days

Female

White

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH

9. AGE (In years, last birthday)

11 Under 1 Year 11 Under 24 Hours
Months: Days Hours: Min.

59

11. BIRTHPLACE (State or foreign country)

Charles County, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert M. Thompson

14. MOTHER'S MAIDEN NAME

Josephine Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

M. Elizabeth Thompson, 2850 N. Charles St.

18. CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

3 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) Arteriosclerosis Heart Disease

DUE TO

6 years

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Repeated Thrombosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

22. I hereby certify that I attended the deceased from January 1946, to March 5, 1950, that I last saw the deceased alive on March 3, 1950, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

2 West Road Street, Balto. Md. 3.20.50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

3.8.50

Woodlawn

Woodlawn, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

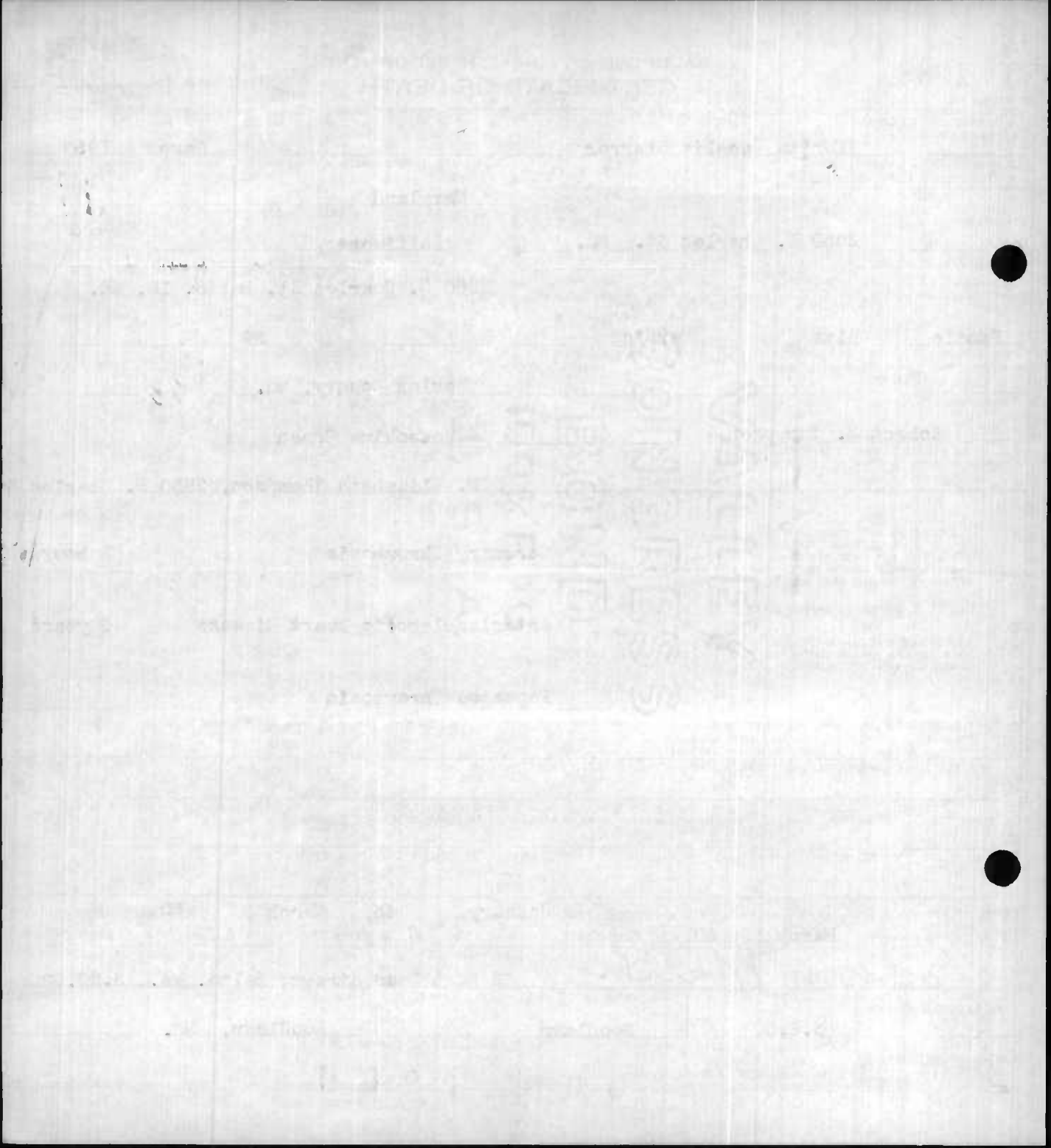
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

Winifred Williams



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 1983

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Edward P. Mc Garrity

2. DATE
OF
DEATH

3-3-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore*

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE

4219 Grace Court

C. Length of stay in Baltimore

Yrs.
Mos.
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore *25-05*

D. STREET ADDRESS (If rural, give location)
4219 Grace Court

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

May 28 - 1879

9. AGE (In years last birthday)

70

10. Under 1 Year Months Days

11. Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Blacksmith

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Scotland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward C. Mc Garrity

14. MOTHER'S MAIDEN NAME

Nora Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Margaret M. Mc Garrity 4219 Grace Court

18. *151X*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Carcinoma of Stomach

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Mar 1*, 19*50*, to *Mar 3*, 19*50*, that I last saw the deceased alive on *Mar 3*, 19*50*, and that death occurred at *1:10 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

Samuel Rubin

23B. ADDRESS

203 Calapascos Ave

23C. DATE SIGNED

3/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-7-1950

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county) (State)

A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR

MAR 6 - 1950

REGISTRAR'S SIGNATURE

Samuel Rubin

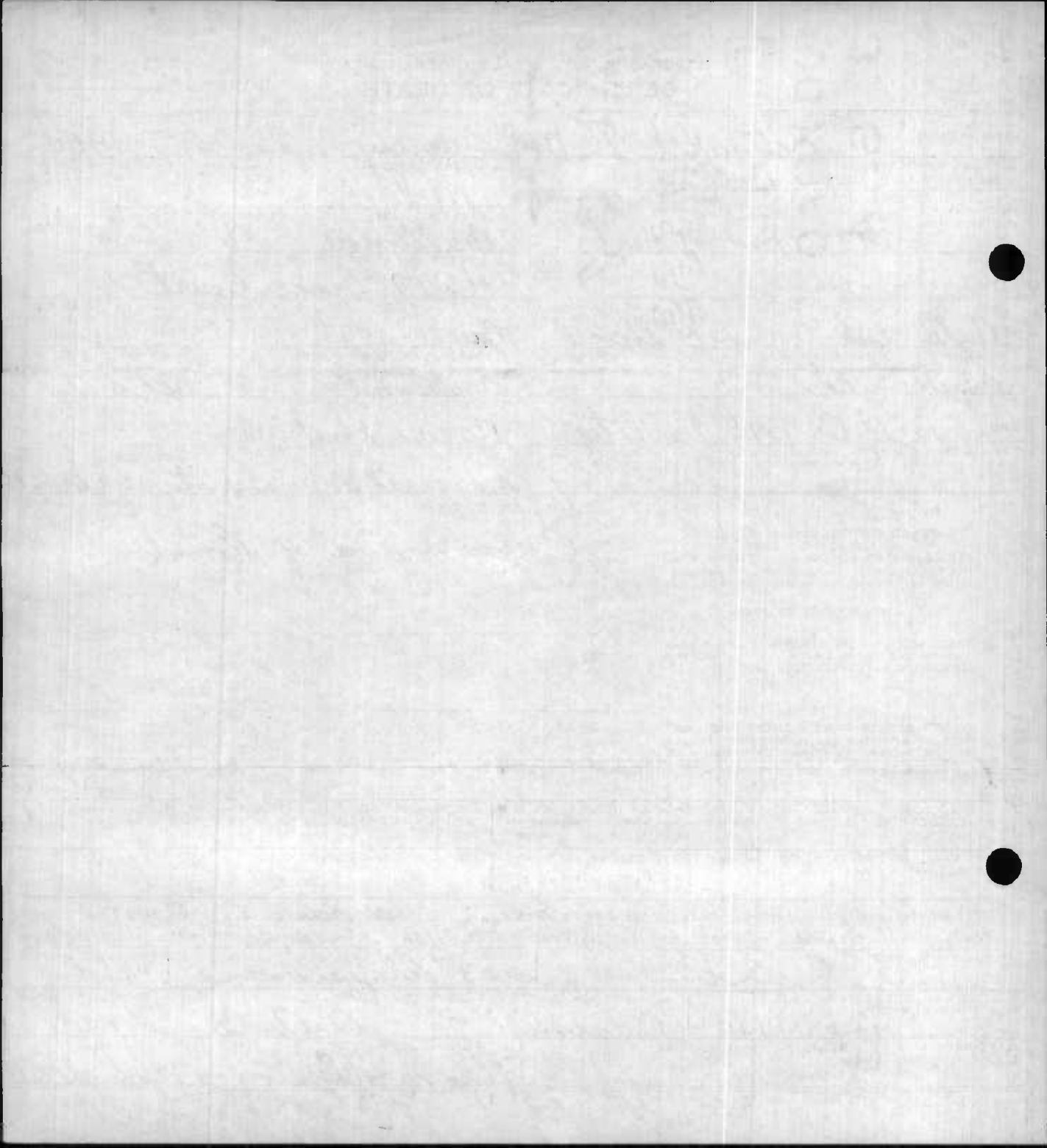
25. FUNERAL DIRECTOR

Fleming & Fleming

ADDRESS

1426 Light St.

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. 50 1984

1. NAME OF DECEASED
(Type or Print) Edgar V. Burrier

2. DATE OF DEATH 3-4-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 25-03A

D. STREET ADDRESS (If rural, give location)
2211 Cedar Ave

Length of stay in Baltimore

5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept. 1-1898 9. AGE (In years last birthday) 61 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10B. KIND OF BUSINESS OR INDUSTRY Mathieson Chemical

11. BIRTHPLACE (State or foreign country) U.S.A. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Burrier

14. MOTHER'S MAIDEN NAME Margaret E. Wallace

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Patricia Burrier (Wife) ADDRESS 2211 Cedar Ave

18. 443X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

Cardiac Decompensation

INTERVAL BETWEEN ONSET AND DEATH

Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

Hypertensive Cardio-Vascular Disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Robert B. McEadden M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ 3/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

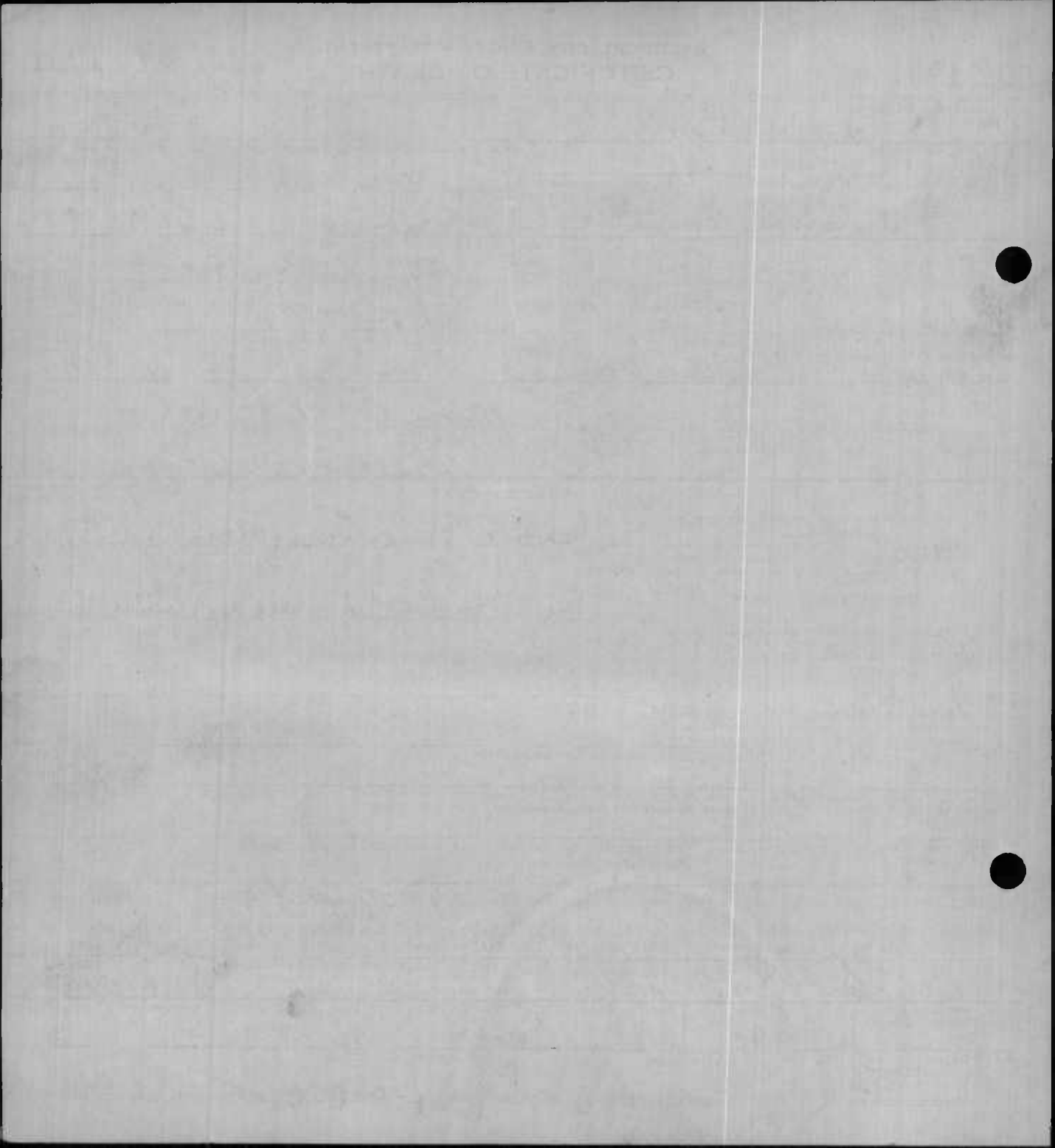
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1985

Registered No.

1. NAME OF DECEASED
(Type or Print)

Elizabeth Schaffer

2. DATE
OF
DEATH

March 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

5300 Gwynn Oak Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5300 Gwynn Oak Ave.

Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widow

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR
INDUSTRY

at home

13. FATHER'S NAME

Ernest Bettenhausen

8. DATE OF BIRTH

Apr. 12, 1868

9. AGE (In years,
last birthday)

81

11 Under 1 Year
Months: Days11 Under 24 Hours
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

- Shafer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mr. Frederick E. Schaffer 3200 Gwynn Oak

Av.

18. 286.5

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

5 yrs

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

mental failure developing

(B)

first years ago precluded any
cooperation on physical exam
Would not eat - spit out food.

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1945, 19, to March 5, 1950, that I last saw the
deceased alive on March 1, 1950, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

H. V. Harper

23B. ADDRESS

M. O.

5201 Gwynn Oak Ave

23C. DATE SIGNED

3/5/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/8/50

24C. NAME OF CEMETERY OR CREMATOR

Woodlawn Cem.

24D. LOCATION (City, town, or county) (State)

Woodlawn, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

MAR 6 - 1950

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.

THE JOURNAL OF THE
SOCIETY OF THE HISTORY OF THE
CITY OF NEW YORK

17

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **50 1986**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES KAY HARFORD

2. DATE
OF
DEATH

Mar. 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2906 Miles Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2906 Miles Ave.

E. Length of stay in Baltimore

life

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

Copper & Brass

13. FATHER'S NAME

Thomas N. Harford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Florence H. Harford 2906 Miles Ave.

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

(A) Coronary insufficiency

6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B) Hypertensive Cardiovascular Dis.

6 yrs?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

DUE TO

(C) Arterial Hypertension

?

Malnutrition and arteriosclerotic changes, atherosclerosis, uraemia

3 mos

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from July, 1949, to Mar. 6, 1950, that I last saw the deceased alive on Mar. 4, 1950, and that death occurred at 6 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Thomas H. Cohen

M. D.

590 Park Heights Ave.

3/6/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/9/50

24C. NAME OF CEMETERY OR CREMATORY

Balto. Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

WM. J. TICKNER & SONS

Balto., Md.

VS 150

3563/1986

121a

CERTIFICATE OF DEATH

IN THE STATE OF NEW YORK

County of _____

City of _____

State of New York

On this _____ day of _____

320
1987BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1987
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
ELSIE MARY LITZ		Mar. 4, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION 1146 Scott St.		A. STATE Md.	
C. Length of stay in Baltimore		B. COUNTY	
5. SEX female		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
6. COLOR OR RACE white		D. STREET ADDRESS (If rural, give location) 1121 Sterrett St.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow		8. DATE OF BIRTH Oct. 21, 1894	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 55	
10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Wm. H. Brass		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME Anna Vanskiver		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Joseph J. Litz	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		ADDRESS 1121 Sterrett St.	

18. 420.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Cirrhosis Liver DUE TO (B) DUE TO (C) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH years
---	---

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar 1 - 1950 to Mar 4, 1950 that I last saw the deceased alive on Mar 4, 1950 and that death occurred at 5 m. from the causes and on the date stated above.					
23A. SIGNATURE Mendelsohn		23B. ADDRESS 651 N Bentall St.		23C. DATE SIGNED 3/6/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/7/50		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		24E. FUNERAL DIRECTOR WM. J. TICKNER & SONS		24F. ADDRESS Balto., Md.	
DATE RECEIVED BY LOCAL REGISTRAR MAR 6 - 1950		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR WM. J. TICKNER & SONS	
VS 150		1987		124B	

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20530

MEMORANDUM FOR THE ATTORNEY GENERAL

DATE: 10/10/70

TO: THE ATTORNEY GENERAL

FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

28. [illegible]

29. [illegible]

30. [illegible]

31. [illegible]

32. [illegible]

33. [illegible]

34. [illegible]

35. [illegible]

36. [illegible]

37. [illegible]

38. [illegible]

39. [illegible]

40. [illegible]

41. [illegible]

42. [illegible]

400
50 1988BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1988

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

ALRETTA M. PFEIL

2. DATE
OF
DEATH March 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR Hood Nursing Home
INSTITUTION 5313 Edmondson Ave.4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)
A. STATE Md.
B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 15-06D. STREET ADDRESS (If rural, give location)
1907 N. Hilton St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
widow

8. DATE OF BIRTH

June 2, 1876

9. AGE (in years
last birthday)

73

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)
housewife10B. KIND OF BUSINESS OR
INDUSTRY
at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Airhart Winters

14. MOTHER'S MAIDEN NAME

Catherine Everhart

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
no16. SOCIAL
SECURITY NO.
no

17. INFORMANT

ADDRESS

Mr. Edgar T. Pfeil 1507 Pentridge Rd.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) *Coronary Thrombosis*
DUE TO

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) *Paraplegia following*
DUE TO *cerebral apoplexy*

5 yrs

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.(C) *Arteriosclerosis*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 17, 1945 to March 5, 1950 that I last saw the
deceased alive on March 4, 1950, and that death occurred at 6:30 PM from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)
(State)

Burial

Mar. 7, 1950

Druid Ridge Cem.

Pikesville,

Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 6 - 1950

WM. J. TICKNER & SONS

Balto., Md.

Grass of Tennessee
Grass of Tennessee
Grass of Tennessee

Grass of Tennessee
Grass of Tennessee
Grass of Tennessee

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. **50** **1989**

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RUDOLPH C. LEINEWEBER, Sr.

2. DATE
OF
DEATH

Mar. 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

**Edgewood Nursing Home
6000 Bellona Ave.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6000 Bellona Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Oct. 4, 1867

9. AGE (In years last birthday)

82

If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired machinist

10B. KIND OF BUSINESS OR INDUSTRY

Experimental

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

August

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Ave.
Mrs. Agnes E. Leineweber 2926 Christopher

18. **306X I**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Procho-pneumonia (terminal)**
DUE TO **a cute Resp Infection**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

In addition, **Cerebral Arteriosclerosis**
& **Senile Dementia.**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

none

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

none

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **March 1, 1950**, to **Mar 3, 1950** that I last saw the deceased alive on **Mar 2, 1950** and that death occurred at **6p** m., from the causes and on the date stated above.

23A. SIGNATURE

W. Edwin Stratt

23B. ADDRESS

712 Park Ave. Balto., Md. 1950

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/6/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Tickner & Sons

25. FUNERAL DIRECTOR

WM. J. TICKNER & SONS

ADDRESS

Balto., Md.

MAR 6 - 1950

VS 150

1991

107

UNITED STATES DEPARTMENT OF HEALTH
CENTRO DE INVESTIGACIONES DE LA SALUD

WATER

Proteínas (aminoácidos)
y sales minerales
disueltas. Los aminoácidos
se absorben fácilmente.

El agua es esencial para la vida.
Se absorbe en el intestino delgado.
El agua es esencial para la vida.
Se absorbe en el intestino delgado.

636
50 1990BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1990
Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

JOHN F. PORTER

2. DATE
OF
DEATH

March 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTION 5506 Fair Oaks St.4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE Maryland B. COUNTYC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore 17-01

D. STREET ADDRESS (If rural, give location)

503 W. Franklin St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Nov. 26, 1887

9. AGE (in years
last birthday)

62

If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Carpenter, retired

10B. KIND OF BUSINESS OR
INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Howard Co., Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Lemuel E. Porter

14. MOTHER'S MAIDEN NAME

Isabel Kirby

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
William Porter, 509 Dunkirk Rd.18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, assthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

(A)

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE ☐
WORK AT WORK22. I hereby certify that I attended the deceased from March 1, 1950, to March 4, 1950 that I last saw the
deceased alive on March 4, 1950, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/7/50

24C. NAME OF CEMETERY OR CREMATORY

St. Johns

24D. LOCATION (City, town, or county) (State)

Howard Co., Md.

DATE RECEIVED BY
LOCAL REGISTRAR

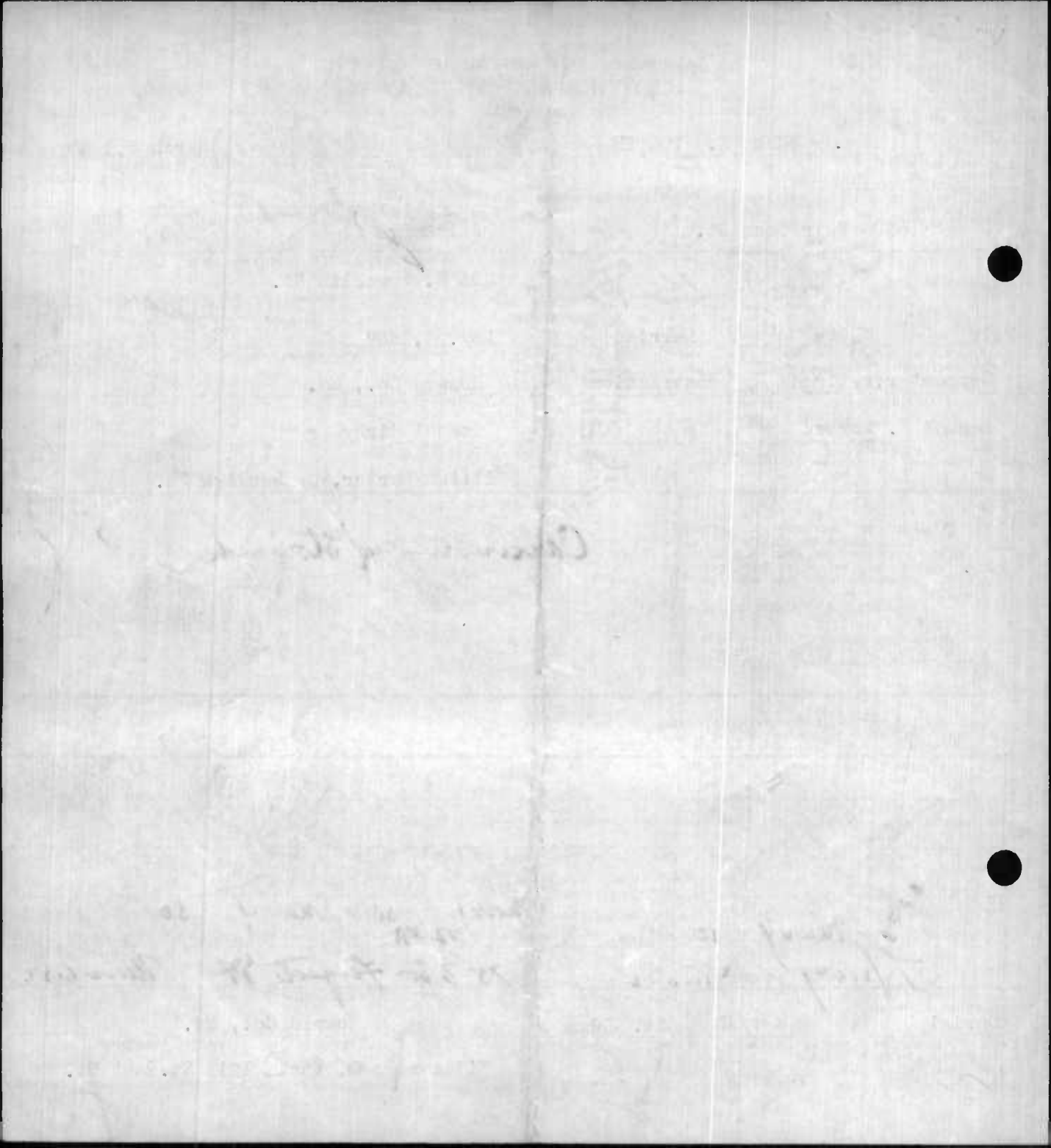
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 7 - 1950

William Coo, Inc. 1217 St. Paul St.



50 1991

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1991

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN A. ESSEX

2. DATE
OF
DEATH

March 3, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

432 Annabel Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

432 Annabell Ave.

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

Apr. 12, 1866

9. AGE (in years
last birthday)

83

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

Laborer retired

10B. KIND OF BUSINESS OR
INDUSTRY

City of Baltimore

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard Essex

14. MOTHER'S MAIDEN NAME

Laura V. Kemp

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Richard Essex, 313 S. Payson St.

1B. *Heart*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN-10, 1949, to March 3, 1950, that I last saw the
deceased alive on March 3, 1950, and that death occurred at 104 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/7/50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county) (State)

Brooklyn, Md.

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

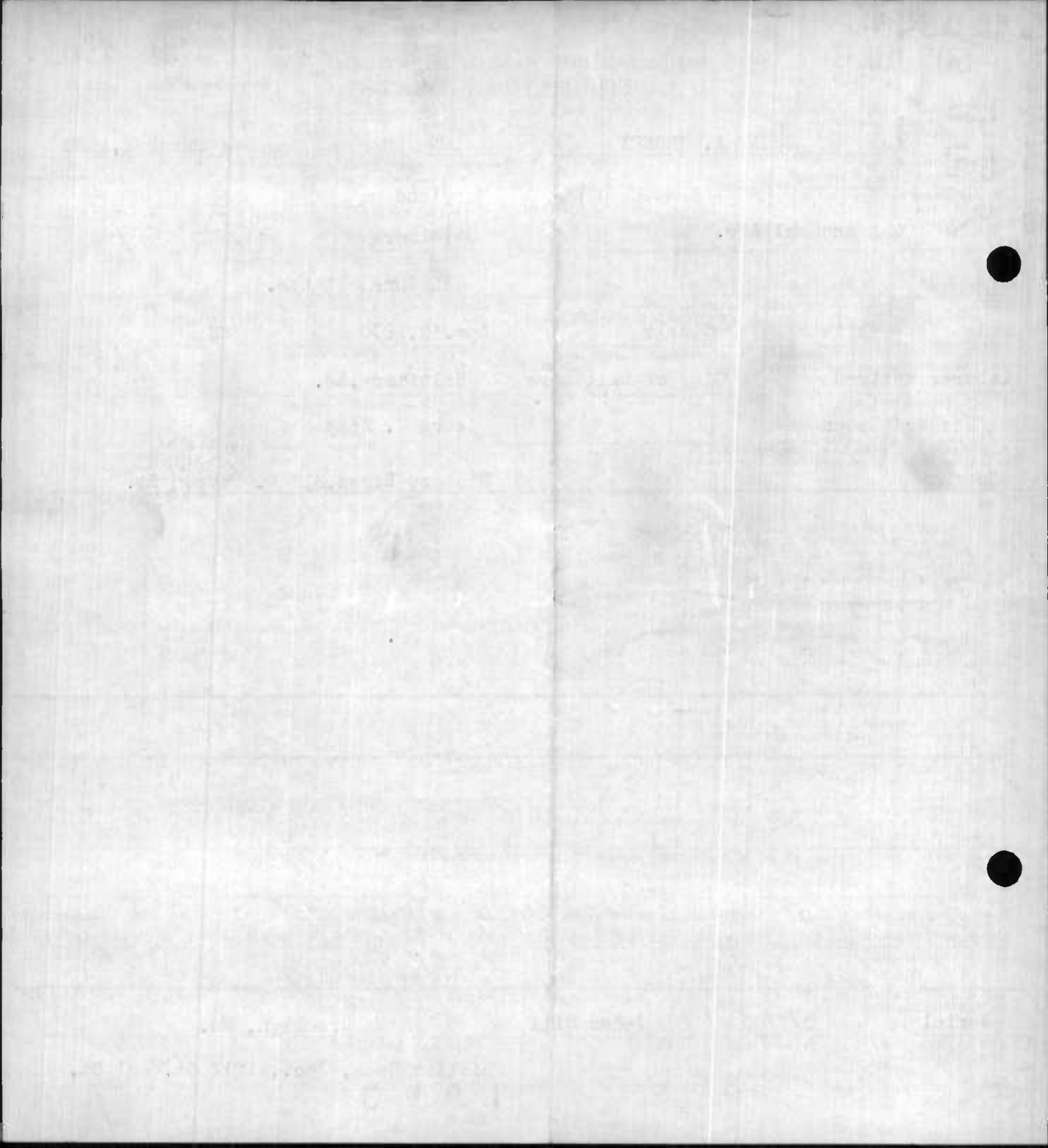
25. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul St.

VS 150

93D



230
50 1992BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH50 1992
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND A. WEST

2. DATE
OF
DEATH

March 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR
INSTITUTION

1758 Carswell St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1758 Carswell St.

c. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)If Under 1 Year
Months: DaysIf Under 24 Hours
Hours: Min

Male

White

Married

July 20, 1898

51

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mail Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Internal Rev. Dept.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Eugene West

14. MOTHER'S MAIDEN NAME

Amelia Worthmore

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.17. INFORMANT ADDRESS
Ellen West, 1758 Carswell St.

18. 162X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Bronchogenic Carcinoma

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

February 1950

19B. MAJOR FINDINGS OF OPERATION

Inoperable Bronchogenic Carcinoma.

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-
LYING ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/26, 1950, to 3/1, 1950, that I last saw the deceased alive on 3/1, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

J. Frank Supply, Jr.

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

3/6/50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

3/8/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

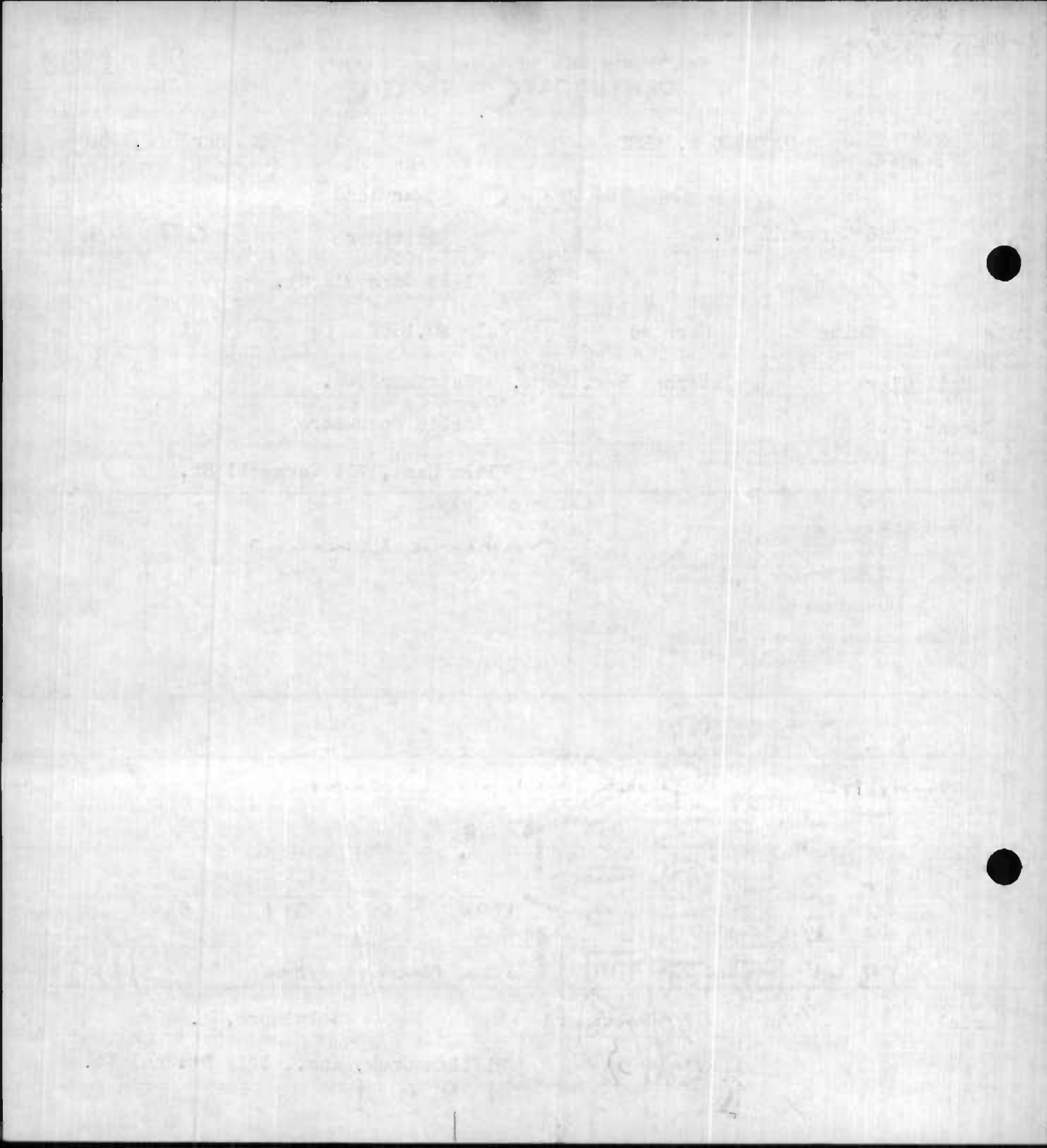
DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul St.



50 1993

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1993

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		CLARENCE THOMPSON		2. DATE OF DEATH		March 6, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2004 Barclay St.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
C. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location) 2004 Barclay St.			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Feb. 1883	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY Any One		9. AGE (In years last birthday) 67		11. BIRTHPLACE (State or foreign country) Baltimore County, Md.	
13. FATHER'S NAME Louis Thompson				12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Ida Wortman				ADDRESS 2004 Barclay St.			

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Coronary thrombosis

1 hr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Arteriosclerotic heart disease

+ 5 yr

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 6 Mar, 1950, to 6 Mar, 1950, that I last saw the deceased alive on 6 Mar, 1950, and that death occurred at 7:48 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

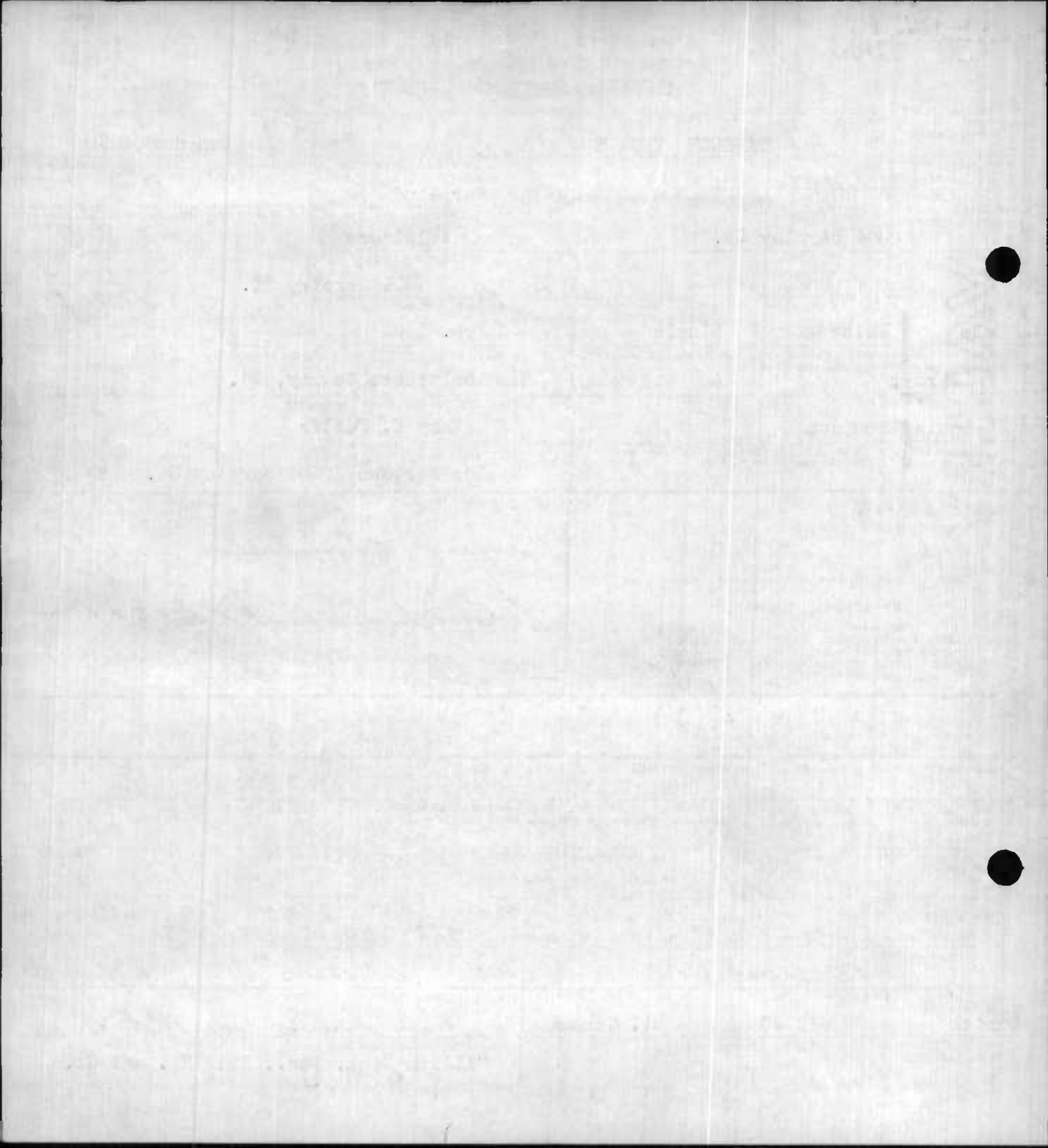
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 3/8/50	24C. NAME OF CEMETERY OR CREMATORY Mt. Carmel	24D. LOCATION (City, town, or county) (State) Balto. Co. Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS

MAR 7 - 1950

William Cook, Inc., 1217 St. Paul St.

VS 150

937



50 1994

BRUSCUP

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 1994
Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROLAND BRUSCUP

2. DATE
OF
DEATH

MARCH 5, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

Stani Hosp

4. USUAL RESIDENCE (Where deceased lived, if institution: residence
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write full R.A.L. and give
township)

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

Yrs.
Mos.
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years, last birth day)

If Under 1 Year
Months: Days
If Under 24 Hours
Hours: Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTH PLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Leila Bruscup, 1376 N. Vt. Ave

18. 581.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A)

Cirrhosis of the liver

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia + Hemoptysis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the
deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. JUNKYAL DIRECTOR

ADDRESS

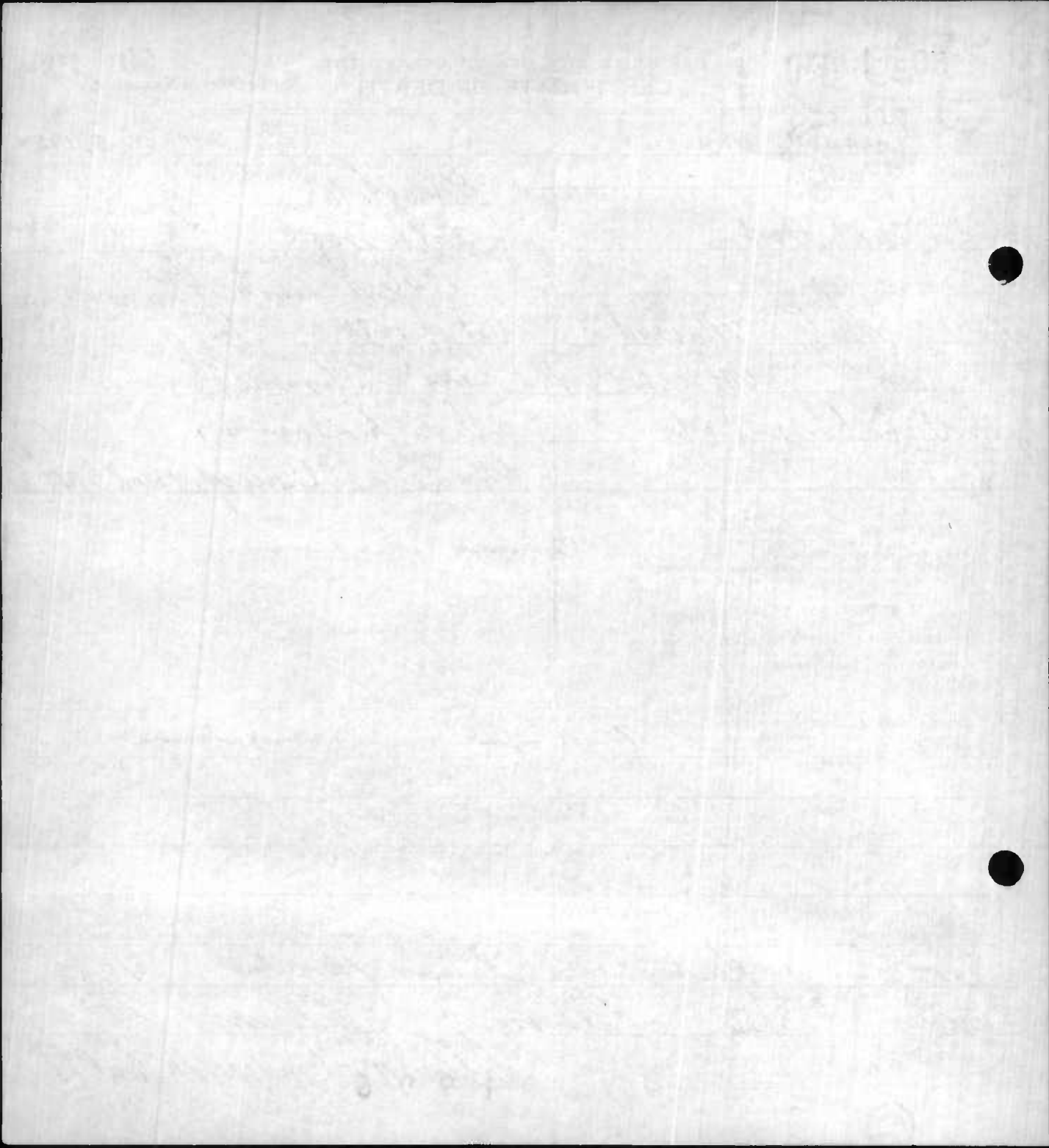
VS 150

26690

124B

MEDICAL CERTIFICATION

Contact age is especially important. Physicians: please write the causes of death clearly and legibly.



AB-1359970

-6250

1995

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1995

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

William Franklin Morris

2. DATE
OF
DEATH

3-5-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
before admission)A. STATE
Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or
HOSPITAL OR INSTITUTION location)Baltimore City Hospitals
4940 Eastern Ave.C. CITY OR TOWN (If outside corporate limits, write RURAL and give
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

831 McKim St.

Length of stay in Baltimore

5yrs

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH

Sept. 1-1879

9. AGE (In years
last birthday)

70

If Under 1 Year
Months DaysIf Under 24 Hours
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert Morris

14. MOTHER'S MAIDEN NAME

Martha Jane

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.17. INFORMANT Baltimore City Hospitals
Records: 4940 Eastern Ave.

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive arteriosclerotic heart disease
with chronic failure
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

Broncho-pneumonia R.U.L.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-
LYING OR CONTRIBUTING
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT ☐ NOT WHILE
WORK AT WORK ☐22. I hereby certify that I attended the deceased from 2-22-1950, to 3-5-1950 that I last saw the
deceased alive on 3-5-1950, and that death occurred at 9.30 AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

Baltimore City Hospitals

3-6-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

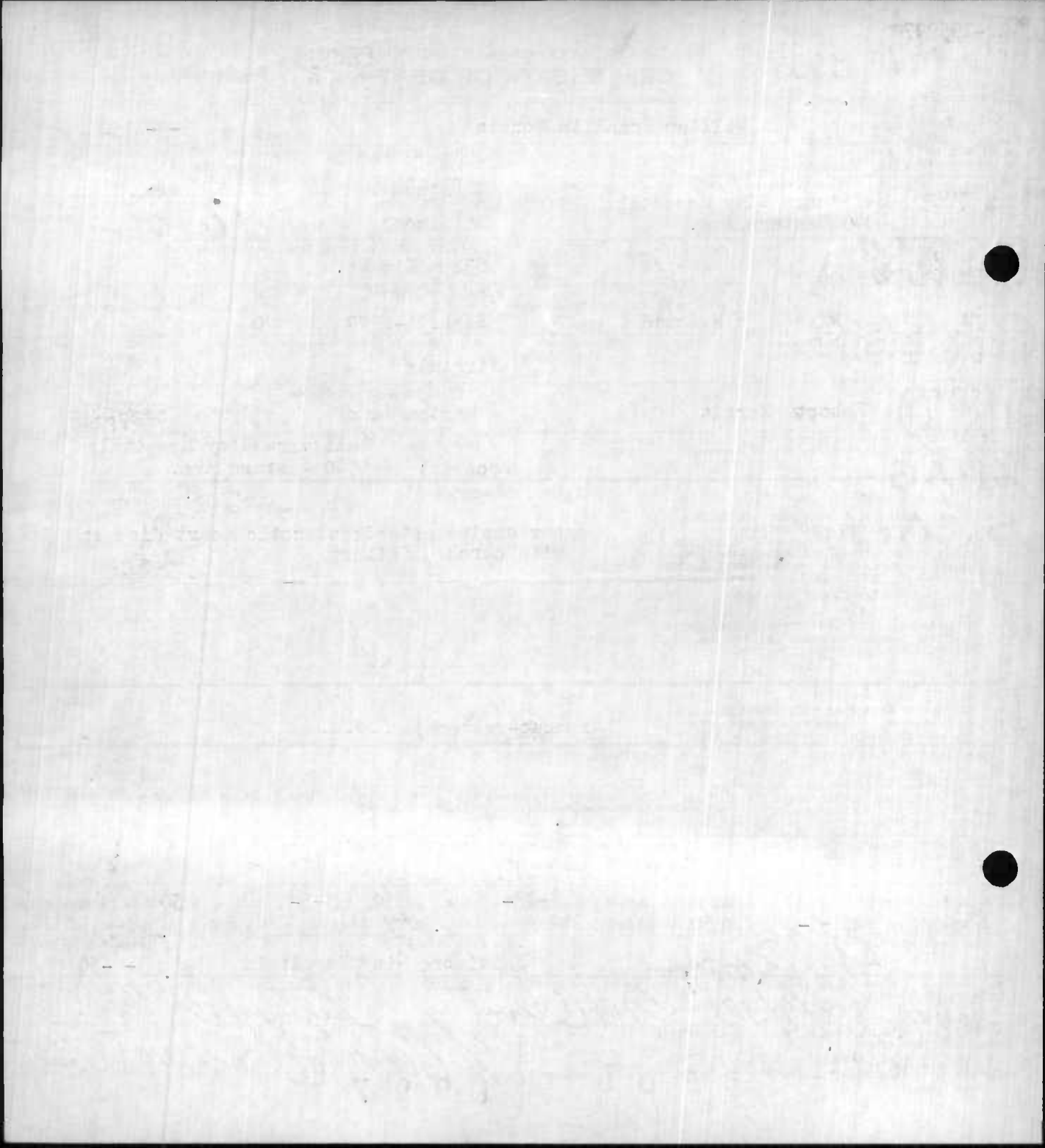
ADDRESS

MAR 7 - 1950

VS 150

MEDICAL CERTIFICATION

93D



3630 1996

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X Registered No. 50 1996

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Melvin D. Hedrick

2. DATE
OF
DEATH

3-5-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence
A. STATE B. COUNTY

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

612 Kingston Rd

E. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan 6, 1896

9. AGE (in years)

34

10. Under 1 Year
Months: Days11. Under 24 Hours
Hours: Min.12. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)13. KIND OF BUSINESS OR
INDUSTRY

Polytechnic

14. BIRTHPLACE (State or foreign country)

Baltimore Md

15. CITIZEN OF
WHAT COUNTRY?

16. FATHER'S NAME

Frank Hedrick Sr

17. MOTHER'S MAIDEN NAME

Caroline Christy

18. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

19. (If yes, give war or dates of service)

20. SOCIAL
SECURITY NO.

21. INFORMANT

William Hedrick, 612 Kingston Rd

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Posterior Myocardial Infarction - 3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

Coronary Thrombosis

3 days

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

m. WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-3, 1950 to 3-5, 1950 that I last saw the
deceased alive on 3-5, 1950, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

23A. SIGNATURE

William J. Hallaway, M.D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

3-6-50

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3/9/50

24C. NAME OF CEMETERY OR CREMATORY

Poplar

24D. LOCATION (City, town, county, State)

Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

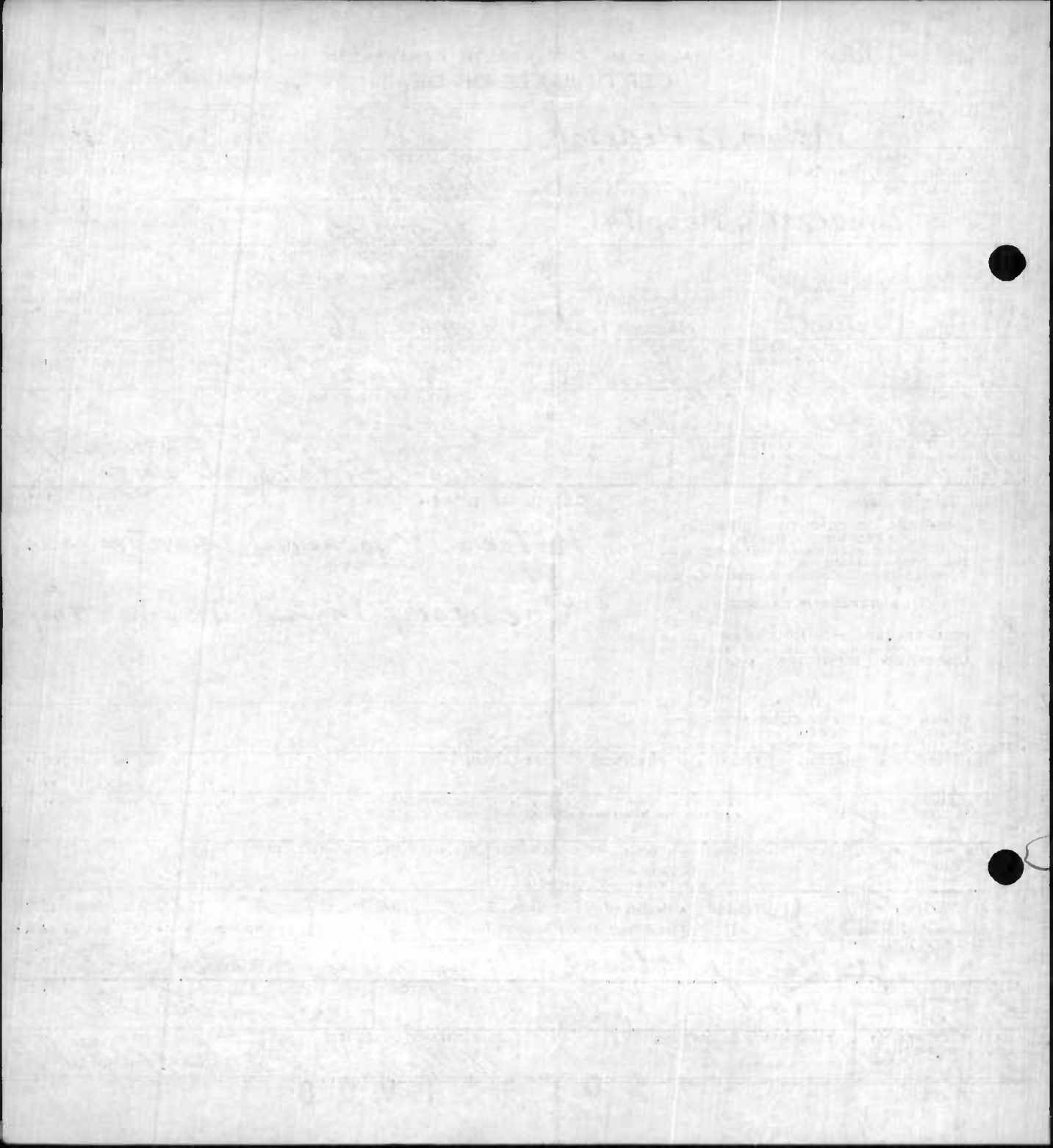
REGISTRAR'S SIGNATURE

William J. Hallaway, M.D.

25. FUNERAL DIRECTOR

ADDRESS

William J. Hallaway, 1214 H. Bond St



630
50 1997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 1997
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Charles P. Crate</i>		2. DATE OF DEATH <i>Mar. 5 - 1967</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Franklin Sq. Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>1448 Homestead St</i> B. COUNTY <i>9-05</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Franklin Square Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1448 Homestead St</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>9-19-1876</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired postal</i>	9. AGE (In years last birthday) <i>73</i>
13. FATHER'S NAME <i>George P. Crate</i>		14. MOTHER'S MAIDEN NAME <i>Bertha E. Chneling</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS

18. *421.4*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cerebral Hemorrhage*
DUE TO *Hypertension*

INTERVAL BETWEEN ONSET AND DEATH
3/3/50

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Endocarditis*
DUE TO

retention

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Hypertension*
DUE TO

3/4/50

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Feb. 26, 1950*, to *Mar 5, 1950*, that I last saw the deceased alive on *Mar 5, 1950*, and that death occurred at *4:15 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O. *817 Medical Art Bldg*

3/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

MAR 7 - 1950

VS 150

26695

92E

MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

**BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH**

Registered No. _____

BIRTH NO. _____

1. NAME OF DECEASED
(Type or Print)

Velez, Fred G.

2. DATE
OF
DEATH

March 4, 1950

3. PLACE OF DEATH:

A. **Baltimore City, Maryland U.S. Marine Hospital**

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

U.S. MARINE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **New York** B. COUNTY _____

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
ROCKY HILL Afton

D. STREET ADDRESS (If rural, give location)
Route 2

E. Length of stay in Baltimore _____

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

mar.

8. DATE OF BIRTH

May 26, 1891

9. AGE (In years
last birthday)

58

If Under 1 Year
Months: Days

7

If Under 24 Hours
Hours: Min.

6

10A. USUAL OCCUPATION (Give kind of
work done during most of working life, even if retired)

AB

10B. KIND OF BUSINESS OR
INDUSTRY

Seaman-Tanker

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF
WHAT COUNTRY?

US

13. FATHER'S NAME

Max Velez

14. MOTHER'S MAIDEN NAME

Mary - - -

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

- - -

16. SOCIAL
SECURITY NO.

Unk.

17. INFORMANT ADDRESS

Records - USMH - Balto., Md.

18. **260X**

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e. g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A)

Lobar Pneumonia Left

QUE TO

INTERVAL BETWEEN
ONSET AND DEATH

5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

QUE TO

(C) Diabetes mellitus with acidosis

II

OTHER SIGNIFICANT CONDITIONS CON-
TRIBUTING TO THE DEATH, BUT NOT RELATED
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **March 3**, 19 **50** to **March 4**, 19 **50** that I last saw the
deceased alive on **March 4**, 19 **50**, and that death occurred at **12:10 AM**, from the causes and on the date stated above.

23A. SIGNATURE

William Remmich

M. O.

23B. ADDRESS

U.S. Marine Hospital, Balto., Md.

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

24B. DATE

3/7/50

24C. NAME OF CEMETERY OR CREMATORY

Moulton Park Baltimore Md

DATE RECEIVED BY
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Remmich

25. FUNERAL DIRECTOR

William Remmich 1214 Bond St

ADDRESS

VS 150

460 51

2000

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Informant		13. Signature of Medical Officer		14. Signature of Coroner		15. Signature of Burial Officer	
16. Signature of Minister of Religion		17. Signature of Undertaker		18. Signature of Cemetery Officer		19. Signature of Health Officer		20. Signature of Police Officer	
21. Signature of School Officer		22. Signature of Social Worker		23. Signature of Nurse		24. Signature of Pharmacist		25. Signature of Dentist	
26. Signature of Veterinarian		27. Signature of Engineer		28. Signature of Lawyer		29. Signature of Judge		30. Signature of Mayor	
31. Signature of Town Clerk		32. Signature of School Board		33. Signature of Board of Health		34. Signature of Board of Police		35. Signature of Board of Fire	
36. Signature of Board of Education		37. Signature of Board of Trade		38. Signature of Board of Agriculture		39. Signature of Board of Commerce		40. Signature of Board of Industry	
41. Signature of Board of Labor		42. Signature of Board of Public Works		43. Signature of Board of Public Safety		44. Signature of Board of Public Health		45. Signature of Board of Public Education	
46. Signature of Board of Public Welfare		47. Signature of Board of Public Assistance		48. Signature of Board of Public Relief		49. Signature of Board of Public Charity		50. Signature of Board of Public Aid	
51. Signature of Board of Public Support		52. Signature of Board of Public Maintenance		53. Signature of Board of Public Preservation		54. Signature of Board of Public Protection		55. Signature of Board of Public Security	
56. Signature of Board of Public Defense		57. Signature of Board of Public Order		58. Signature of Board of Public Peace		59. Signature of Board of Public Justice		60. Signature of Board of Public Equity	
61. Signature of Board of Public Fairness		62. Signature of Board of Public Honesty		63. Signature of Board of Public Integrity		64. Signature of Board of Public Virtue		65. Signature of Board of Public Honor	
66. Signature of Board of Public Reputation		67. Signature of Board of Public Character		68. Signature of Board of Public Fame		69. Signature of Board of Public Glory		70. Signature of Board of Public Honor	
71. Signature of Board of Public Respect		72. Signature of Board of Public Esteem		73. Signature of Board of Public Admiration		74. Signature of Board of Public Approval		75. Signature of Board of Public Praise	
76. Signature of Board of Public Commendation		77. Signature of Board of Public Acclaim		78. Signature of Board of Public Applause		79. Signature of Board of Public Cheers		80. Signature of Board of Public Cheers	
81. Signature of Board of Public Cheers		82. Signature of Board of Public Cheers		83. Signature of Board of Public Cheers		84. Signature of Board of Public Cheers		85. Signature of Board of Public Cheers	
86. Signature of Board of Public Cheers		87. Signature of Board of Public Cheers		88. Signature of Board of Public Cheers		89. Signature of Board of Public Cheers		90. Signature of Board of Public Cheers	
91. Signature of Board of Public Cheers		92. Signature of Board of Public Cheers		93. Signature of Board of Public Cheers		94. Signature of Board of Public Cheers		95. Signature of Board of Public Cheers	
96. Signature of Board of Public Cheers		97. Signature of Board of Public Cheers		98. Signature of Board of Public Cheers		99. Signature of Board of Public Cheers		100. Signature of Board of Public Cheers	

CERTIFICATE CORRECTED

3-8-50

50 1999

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Andrew Johnson

2. DATE
OF
DEATH

3-3-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE Baltimore City Hospitals
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

642 Coakesburg Rd. (Cokesburg Rd)

5. Length of stay in Baltimore

69yrs

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

June 7- 1861 1862

9. AGE (In years last birthday)

88 87

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Richmond, Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Richard E. Johnson

14. MOTHER'S MAIDEN NAME

Mary Morris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Baltimore City Hospitals
Records: 4940 Eastern Ave.

18. 420.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-11-1946 to 3-3-1950, that I last saw the deceased alive on 3-3-1950, and that death occurred at 8.20Pm., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

Baltimore City Hospitals

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

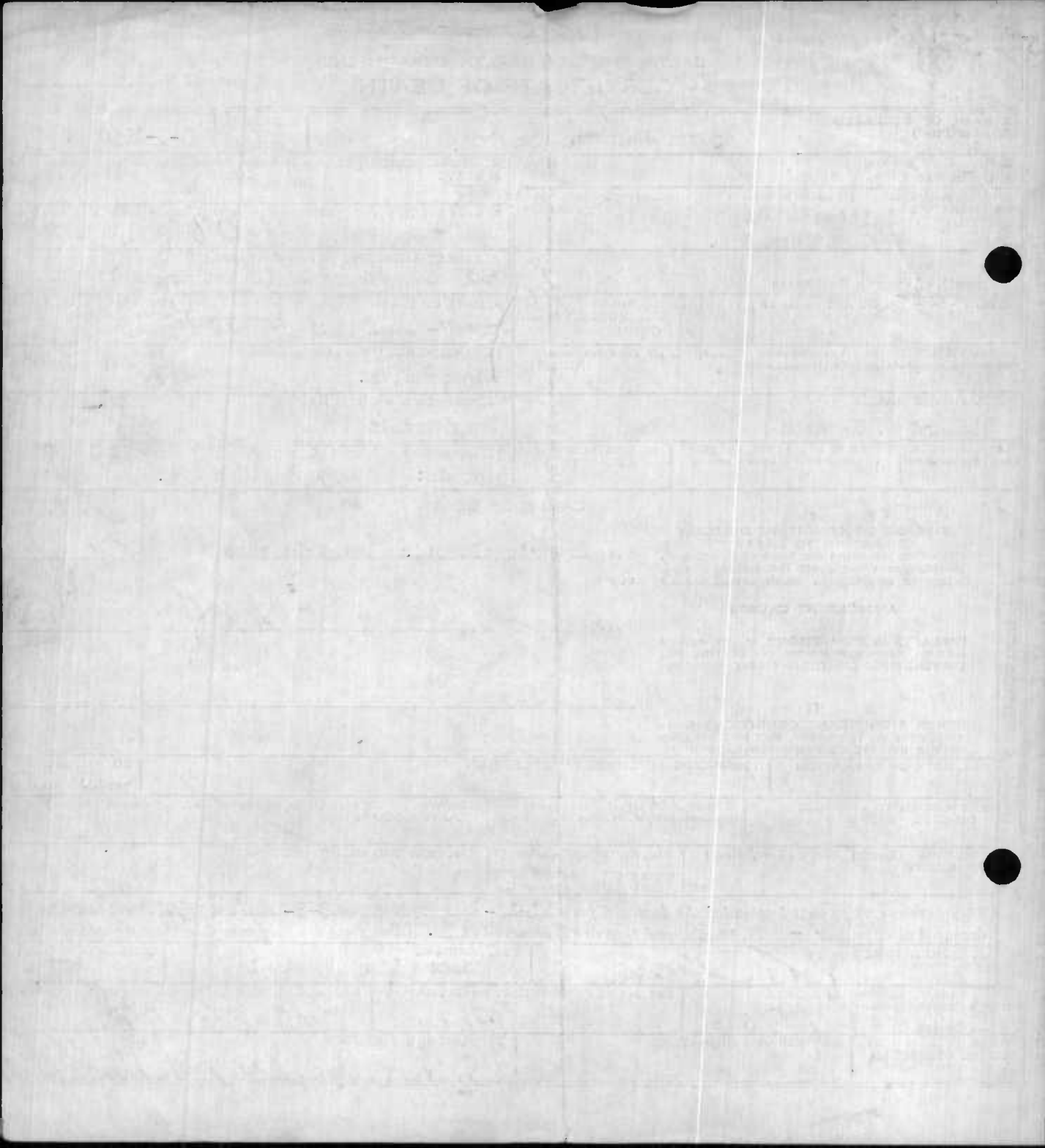
(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



245
50 2000M^cWILLIAMS
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 2000

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mary McWilliams</i>		2. DATE OF DEATH <i>3.4.50</i>				
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>P.F. died in ambulance on way to St Joseph's Hosp.</i> C. Length of stay in Baltimore Yrs. Mos. Days		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 9-07</i> D. STREET ADDRESS (If rural, give location) <i>2553 Kirk Ave</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>Sept 19, 1872</i>	9. AGE (In years last birthday) <i>77</i>	10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Patrick J. Hart</i>		14. MOTHER'S MAIDEN NAME <i>Rose Croen</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Joseph McWilliams</i>		ADDRESS <i>2553 Kirk Ave</i>		
18. <i>421.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO		CAUSE OF DEATH <i>Heart Block; complete</i>		INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		(B) <i>Coronary Arteriosclerosis</i>		<i>15 years</i>		
(C) <i>Diabetes Mellitus, Mild</i>				<i>15 years</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<i>over</i>		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>Sept 20, 1949</i> to <i>Mar</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>3-3</i> , 19 <i>50</i> , and that death occurred at <i>9:30</i> m., from the causes and on the date stated above.						
23A. SIGNATURE <i>Thomas J. Brennan</i> M. P.		23B. ADDRESS <i>5217 Harford Road</i>		23C. DATE SIGNED <i>3-4-50</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3/9/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>National</i>		24D. LOCATION (city, town, or county) (State) <i>Baltimore Md</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>Mar 7 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams</i>		25. FUNERAL DIRECTOR <i>Thorn & Son</i>		ADDRESS <i>1211 E. Paul St</i>

51

Letter in document file 50-2000 4/10/50